

**Nursing and Midwifery Council  
Fitness to Practise Committee**

**Substantive Hearing  
Monday, 10 November 2025 – Monday 17 November 2025  
Wednesday, 7 January 2026 – Tuesday 13 January 2026  
Thursday, 26 March 2026 – Friday, 27 March 2026 (In Camera)  
Monday, 30 March 2026 – Tuesday, 31 March 2026**

Virtual Hearing

**Name of Registrant:** Mollie Nabitaka

**NMC PIN:** 21H2502E

**Part(s) of the register:** Nurses part of the register Sub part 1  
RNA: Adult nurse, level 1 – 02 March 2022

**Relevant Location:** Bedfordshire

**Type of case:** Lack of competence

**Panel members:** Caroline Rollitt (Chair, lay member)  
Idris Gbadamosi (Registrant member)  
Lynne Vernon (Lay member)

**Legal Assessor:** Ian Ashford-Thom (10 Nov – 17 Nov 2025)  
Angus Macpherson (7 Jan – 13 Jan 2026)  
Ian Ashford-Thom (26 March – 31 March 2026)

**Hearings Coordinator:** Monowara Begum (10 November 2025 – 13  
January 2026)  
Samara Baboolal (26 March – 31 March 2026)

**Nursing and Midwifery Council:** Represented by Omar Soliman, Case Presenter

**Ms Nabitaka:** Present and represented by Neomi Bennett,  
Equality 4 Black Nurses (10 Nov – 17 Nov 2025)  
Present and not represented (7 Jan – 13 Jan  
2026, 30-31 March 2026)

**Facts proved:** 1(a), 1(b), 1(c), 2(a), 2(b), 3(a), 3(b), 4(a), 4(c), 5(a), 5(b), 6(a), 6(b), 6(c), 7(a), 7(b), 8, 9(a), 9(b), 9(c), 9(d), 9(e), 9(f), 9(h), 9(i), 9(j), 9(m), 10, 11, 12(a), 12(b), 12(c), 12(e), 12(f), 12(g), 12(h), 13(a), 13(b), 13(c)

**Facts not proved:** 4(b), 9(g), 9(k), 9(l), 12(d)

**Fitness to practise:** Impaired

**Sanction:** Conditions of practice order (18 months)

**Interim order:** Interim conditions of practice order (18 months)

## **Details of charge**

That you, between 10 May 2022 and 14 October 2023 failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 Nurse:

- 1) On 13 June 2022:
  - a) Administered Amlodipine 5mg to Patient D in circumstances where you did not consult a doctor to check if an additional 5mg should be administered, as per the prescription and/or query if the prescription was correct.
  - b) Had to be prompted to check patients' wristbands prior to administering medication.
  - c) Did not timeously administer medication to patients.
  
- 2) On or around 20 June 2022:
  - a) Did not administer Patient E's insulin at the prescribed time.
  - b) Did not check the wristband of one or more patients prior to the administration of medication.
  
- 3) On 22 June 2022:
  - a) Did not timeously complete a drug round.
  - b) Did not timeously complete patient observations.
  
- 4) On 1 August 2022:
  - a) Inappropriately dispensed medication for two patients at the same time.
  - b) Did not use the online patient system to verify patients' details when conducting a drug round.

- c) Did not timeously reposition patients, as required.
- 5) On 1 November 2022:
- a) Did not administer Tinzaparin to an unknown patient at 14:00, as prescribed.
  - b) Did not record why you had not administered Tinzaparin to an unknown patient at 14.00.
- 6) On 22 November 2022:
- a) Did not conduct checks of your allocated patients, at the commencement of the shift. Did not make enquiries, adequately or at all, in respect of Patient A3's chest drain at handover.
  - b) Did not timeously commence a drug round.
  - c) Did not timeously prepare Patient A4's oxygen venturi mask.
- 7) On 1 December 2022:
- a) Did not provide an adequate handover of your allocated patents' diagnoses and/or treatment upon receiving a request for this information from Colleague A.
  - b) Did not conduct checks of your allocated patients, at the commencement of the shift.
- 8) On 6 July 2023 did not conduct Patient A's water flush and/or PEG feed at 08:00, as prescribed.
- 9) On 28 July 2023:
- a) Did not timeously complete Patient H's Electrocardiogram ("ECG").
  - b) Inappropriately left disused plastic electrodes in Patient H's bed, following the ECG procedure at charge 9a).
  - c) Inappropriately shouted at Colleague B on receiving his suggestion that Patient N be tested for Coronavirus-19.

- d) Did not respond to and/or ignored Patient O who was pressing their buzzer for assistance.
  - e) Inappropriately refused to assist Colleague C with cleaning Patient O.
  - f) Inappropriately shouted at Colleague B on receiving a request to monitor a bay while he took Patient P to the toilet.
  - g) Inappropriately directed that Patient R's food tray be taken away, without first trying to encourage and/or assist them to eat.
  - h) Did not update and/or sign Patient J's Essential Care Record ("ECR").
  - i) Did not administer Patient K's Cetraben cream at 18:00, as prescribed.
  - j) Did not assist colleagues to reposition Patient K and/or Patient L.
  - k) Did not administer Metformin to Patient L between 17:00 and 18:00, as prescribed.
  - l) Did not administer Bisoprolol to Patient H at 08:00, as prescribed.
  - m) Left medication unattended on Patient R's bedside table.
- 10) On a date unknown, inappropriately shouted at Colleague B in response to his request for assistance in feeding a patient.
- 11) On a date unknown, had to be prompted to refrain from administering medication to an unknown patient as it would amount to an overdose.
- 12) On 21 August 2023:
- a) Did not administer Patient B's insulin at 08:00, as prescribed.
  - b) Did not administer Patient C's insulin at 08:00, as prescribed.
  - c) Did not demonstrate awareness of the possible side-effects of administering insulin after the prescribed time.
  - d) Inappropriately refused to assist Colleague D with washing patients and/or conducting observations.
  - e) Did not timeously check Patient A2's blood pressure.
  - f) Did not timeously complete a drug round.

- g) Did not timeously check an unknown patient's temperature.
- h) Did not administer Co-beneldopa to Patient M at the prescribed times of:
  - i. 08:00
  - ii. 12:00
  - iii. 16:00

13) On 10 September 2023:

- a) Did not adhere to infection control procedure in that you used the same insulin pen on two or more patients.
- b) Did not conduct prescribed skin checks in respect of:
  - i. Patient T
  - ii. Patient U
  - iii. Patient V
  - iv. Patient W
  - v. Patient X

Or in the alternative did not record you had conducted the skin checks.

- c) Did not administer one or more of the medications at Schedule 1 to patients at the prescribed time.

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

### **SCHEDULE 1**

Humulin 1 to Patient T at 18:00

Co-beneldopa to Patient M at 16:00

Magnesium Aspartate to Patient Y at 08:00

Macrogol to Patient Z at 18:00

Codeine to Patient A1 at 12:00

## **Background**

The Nursing and Midwifery Council (NMC) received a referral on 20 October 2023 from Bedford Hospital NHS Trust (the Trust).

You were employed at the Trust from 10 May 2022 to 14 October 2023 as a Band 5 nurse. You were initially working on Ward 10 (the Ward), Elderly, Respiratory ward. Your role on the Ward involved taking handovers from night shift staff, the delivery of patient care, carrying out drug rounds and observations, providing personal care to patients, escalating deteriorations, completing patient documentation and communicating with the team.

Shortly after commencing work with the Trust, concerns started to arise in respect of your practice. These concerns included medication administration and management, time management, record keeping and working co-operatively with colleagues.

Your initial probation objective meeting took place on 22 June 2022, whereby Specific, Measurable, Attainable, Relevant, Time-bound (SMART) objectives, and an action plan were formulated to help address and remediate the concerns, which were due to be reviewed in August 2022.

On 1 August 2022, the first formal review of your probation took place, and it was conveyed that your performance on the Ward was continuing to not meet the Trust's standards and expectations despite clear objectives and an action plan being devised during your previous meeting.

On 1 November 2022, a second formal review took place whereby concerns were still identified, and it was decided that your probationary period would be further extended by one month with an action plan.

On 11 November 2022, the Action Plan meeting took place.

On 2 and 13 December 2022, further meetings were held, resulting in you being informed that due to a lack of improvement in your practice the matter was going to be referred to a formal probation hearing.

You had extensive periods of supernumerary practice, and when the supernumerary periods were removed on the assumption that you were ready to work unsupervised, concerns reoccurred, and you were brought back under further periods of supernumerary as you were deemed not ready to work in an unsupervised capacity.

On 31 January 2023, the probation review hearing took place whereby the decision was made to redeploy you to Ward 15, an elderly medicine ward, which was a less acute setting, with the first month being supernumerary. Your probation period was extended for a further three months. A further probation review meeting was arranged for 19 May 2023, however, it was determined that there had been a miscommunication with setting SMART objectives, and as a result the hearing was postponed, and your probation was extended for a further three months.

On 13 June 2023, an Action Plan meeting was held and thereafter you completed Intermediate Life Support Training, and your preceptorship was signed off, and you were considered to show good management of patients. However, concerns continued to persist in areas of medication administration, working co-operatively, time management and record keeping.

On 12 September 2023, due to ongoing concerns despite the extensive support, you were dismissed at the probation hearing, on the grounds that you had failed to meet the

requirements of your probation. The dismissal was effective from 13 October 2023. You appealed the decision, but this was not upheld.

## **Representation**

On Wednesday 7 January 2026, the panel were informed that you were no longer being represented by Ms Bennett, and that you would be representing yourself. You told the panel that you are happy to continue and do not wish to delay it any longer as this has been ongoing for almost three years.

## **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 Mr Soliman on behalf of the NMC and by you.

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

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

- Witness 1: Currently employed by the Trust as a Practice Development Nurse (PD Nurse) in Respiratory and Cross-site, based on Ward 3, Ward 10 and Pilgrim (Respiratory Ward)

- Witness 2: Currently employed by the Trust as a Senior Registered Nurse (RN) and Ward Manager on Ward 10
- Witness 3 Currently employed by the Trust as a Ward Manager on the Department of Medicine for the Elderly Ward
- Witness 4/Colleague B Currently employed by the Trust as a Band 2 Healthcare Assistant (HCA) on Ward 15
- Witness 5/Colleague D Currently employed by the Trust as a Healthcare Assistant (HCA) on Ward 15 at Luton and Dunstable Hospital (the Hospital)
- Witness 6 Currently employed by the Trust as a Ward Manager at Luton and Dunstable Hospital on Ward 15
- Witness 7 Currently employed by Luton and Dunstable NHS Trust as a Senior Registered Nurse at Luton and Dunstable Hospital NHS Trust on Ward 15
- Witness 8 Currently employed by the Trust as a Band 6 Registered Nurse (RN) on Ward 10

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. It considered the witness and documentary evidence provided by both the NMC and you.

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

### **Charge 1(a)**

1) On 13 June 2022:

- a) Administered Amlodipine 5mg to Patient D in circumstances where you did not consult a doctor to check if an additional 5mg should be administered, as per the prescription and/or query if the prescription was correct.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1.

Witness 1 was a Practice Development Nurse (PDN) and part of her role involved supervising Band 5 registered nurses both during and after their supernumerary period. This was to see how they prioritise their work and to evaluate whether they need support and further training.

The panel noted that Witness 1 in her NMC witness statement stated:

*'I did not feel as though Miss Nabitaka was safe to be off supernumerary shifts.'*

On your behalf, Ms Bennett cross-examined Witness 1, for example by asserting that Witness 1 perpetuated racial bias by not standing up for you and not finding out about who

these people were that were bullying you and harassing you because you are black. She submitted that Witness 1's approach to you combined excessive control, selective working and recording and assumptions of dishonesty.

The panel carefully considered this; however, it rejected this matter.

The panel determined that Witness 1's local statement and NMC witness statement were consistent with her oral evidence.

In the Management Record dated 13 June 2022, Witness 1 stated:

*'During the drug round, one of her patient's had amlodipine 5mg prescribed twice. Asked Mollie what she was going to do, for which she answered she was only going to give 5mg and omit the second dose as they have been doing the day before. Explained to Mollie that, the best course of action would be to check the patient's blood pressure so she could discuss the situation with the doctor, as it might have been a prescribing error or the doctors could want the 10mg to be given. Also avoiding this way a potential drug error if amlodipine was prescribed twice in error.'*

During cross-examination you told the panel that you cannot recall the incident, and you do not recall Witness 1 mentioning it to you.

The panel found Witness 1's evidence to be clear and consistent throughout and on the balance of probability determined that this is more likely than not to have happened.

Accordingly, the panel found charge 1a proved.

### **Charge 1(b)**

- 1) On 13 June 2022:
  - b) Had to be prompted to check patients' wristbands prior to administering medication.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1.

The panel noted Witness 1, in the Management Record dated 13 June 2022 stated:

*'Observed Mollie during morning drug round, had to remind her to read patient's wristbands and follow the 5 rights of medication before administering drugs.'*

Witness 1 reiterated this in her oral evidence and the NMC witness statement.

You told the panel that you cannot recall this incident, and you do not recall having this conversation with Witness 1. You told the panel that you know the five rights of medication.

The panel found Witness 1 to be consistent in her evidence throughout, and determined that it was more likely than not that this did occur.

Accordingly, the panel found charge 1b proved.

**Charge 1(c)**

- 1) On 13 June 2022:
  - c) Did not timeously administer medication to patients.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1.

The panel noted Witness 1, in the Management Record dated 13 June 2022 stated:

*'Discussed with Mollie that she needed to learn how to dispense medication quicker, whilst being safe as she spent more than 2 hours to administer oral medications to 5 patients.'*

You told the panel that you cannot recall this incident and that you would never take two hours to administer oral medications to five patients.

The panel found Witness 1's evidence to be consistent and therefore found charge 1c proved.

**Charge 2(a)**

2) On or around 20 June 2022:

a) Did not administer Patient E's insulin at the prescribed time.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1.

The panel noted Witness 1, in the Management Record dated 17 June 2022 stated:

*'During the round, there was a patient who came overnight who did not bring his insulin with him and noticed Mollie skipped his insulin. When*

*asked for reasoning she stated the patient's wife would bring his insulin in the afternoon. Advised Mollie that diabetic patients needed their insulin on time and that was not an acceptable course of action...'*

The panel noted that during cross-examination you had said you were knowledgeable now and demonstrated some knowledge around your management of patients with insulin. However, you also stated that you cannot recall this incident and you would never do this. The panel further noted that this was mentioned to you in the Probation Meeting on 22 June 2022 and was highlighted as one of your objectives to improve.

The panel noted that this was a specific role of Witness 1 carrying out as PDN. The panel determined that Witness 1 was consistent throughout in her evidence with the contemporary evidence and therefore on the balance of probability it is more likely than not that this happened.

Accordingly, the panel found charge 2a proved.

### **Charge 2(b)**

2) On or around 20 June 2022:

- b) Did not check the wristband of one or more patients prior to the administration of medication.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1.

The panel noted Witness 1, in the Management Record dated 17 June 2022 stated:

*'Also during the drug round had to keep reminding her she needs to verify patient's wristbands and to always follow the five rights of medication before administering patient's medication.'*

Witness 1 reiterated this in her NMC witness statement and oral evidence.

You told the panel that you cannot recall this incident.

The panel noted that this was mentioned to you in your Probation Meeting on 22 June 2022 and formed part of your objectives to improve.

The panel determined that Witness 1 was consistent in her evidence and therefore found charge 2b proved.

### **Charge 3(a-b)**

3) On 22 June 2022:

- a) Did not timeously complete a drug round.
- b) Did not timeously complete patient observations.

### **These charges are found proved.**

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

Witness 3 is the Ward Manager and is responsible for overseeing the care provided to patients by the staff on the Ward. She is responsible for providing clinical leadership and management of the staff on the Ward. This includes staff appraisals and development, and supporting and mentoring staff whilst on the Ward.

The panel considered the Management Record dated 1 June 2022 which outlines Witness 3's observation of you during a clinical round.

This is further clarified in Witness 3's NMC witness statement which states:

*'Miss Nabitaka began the drug rounds for 10 patients on the Ward at 07:50 and finished at approximately 10:20. Although the Ward is generally busy, this was a usual allocation of patients on the Ward for one nurse to administer medications to during the drug rounds. I was conscious that observation rounds are required to be completed by 11:00 for all patients on the Ward. by 11:00, Miss Nabitaka had only completed four of her patients' observations. At 11:00, I requested one of the Healthcare Assistants ("HCAs") on shift, although I cannot recall their name, to support Miss Nabitaka with her observations. I recall that the other six patients left for observations were mostly completed by the HCA.'*

Witness 3 further reiterated this in her oral evidence when she spoke about the work she was doing with you, for example, *'supportive measures that Mollie was listening to her'*.

The panel noted that this was also mentioned to you in the Probation Meeting on 22 June 2022 and formed part of your objectives to improve.

Accordingly, the panel found charges 3a and 3b proved.

#### **Charge 4(a)**

- 4) On 1 August 2022:
  - a) Inappropriately dispensed medication for two patients at the same time.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1.

Witness 1, whilst observing in her role as a PDN, noted and recorded in the Management Record dated 1 August 2022:

*'During the drug round I had to support another member of staff with a deteriorating patient, when I came back to continue to observe MN, noticed she was dispensing medication for two different patients at the same time. Immediately told MN this was bad practice and extremely unsafe, therefore she should not repeat it again.'*

The panel noted that there were two other witnesses present in the Probation Meeting on 1 August 2022, namely, Witness 2 and Witness 3. Witness 1 had reiterated what she had seen during her observation in the Probation Meeting.

In your oral evidence you told the panel that you would never do that.

The panel determined that Witness 1 was consistent throughout her evidence and on the balance of probabilities it is more likely than not that this had occurred.

Accordingly, the panel found charge 4a proved.

#### **Charge 4(b)**

4) On 1 August 2022:

- b) Did not use the online patient system to verify patients' details when conducting a drug round.

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1.

The panel noted Witness 1, in the Management Record dated 1 August 2022 stated:

*'Also, during the drug round I noticed MN was asking the patient's DOB and name but not asking about their allergies to. MN was also not taking her ipad with her nervecentre with her and when asked about her current patient's DOB to whom she was about to administer medication, she did not know and had to come back to the desktop to check.'*

Witness 1 clarifies this in her NMC witness statement:

*'...Furthermore, Miss Nabitaka was carrying out her medication round from the desktop computer outside of the patient bay. I had previously advised Miss Nabitaka to use the laptop or mobile devise when completing drug rounds. The Nerve Centre is the online patient system we use when carrying out medication administration...'*

In your oral evidence you told the panel that you remember this incident and remember that the iPads were in short supply that day, and you told the panel that you *'prefer using the desktop'*.

The panel determined that the evidence shows that you did use the online patient system, albeit you used the desktop which prolonged the time in which you undertook the medication round, and therefore finds charge 4b not proved.

#### **Charge 4(c)**

4) On 1 August 2022:

c) Did not timeously reposition patients, as required.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 1.

The panel noted Witness 1 in her NMC witness statement stated:

*'concerns with time management. I referred Miss Nabitaka to examples of where she has been unable to timely manage her workload throughout the shift thus compromising client care, for example, delays in drug rounds, observations and patient repositioning. I witnessed Miss Nabitaka's delay with patient repositioning on multiple shifts and specifically, on 1 August 2022. On this occasion, I completed the patients repositioning for Miss Nabitaka's patients, although I cannot recall names of these patients.'*

During cross-examination you told the panel, *'I always reposition my patients'*.

The panel determined that it is more likely than not that you did not timeously reposition patients as required, and Witness 1 had to intervene.

Accordingly, the panel found charge 4c proved.

**Charge 5(a-b)**

5) On 1 November 2022:

a) Did not administer Tinzaparin to an unknown patient at 14:00, as prescribed.

b) Did not record why you had not administered Tinzaparin to an unknown patient at 14.00.

**These charges are found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 2.

Witness 2 is a Senior Registered Nurse and Ward Manager on Ward 10. She is responsible for the staff on the Ward and for overseeing the care that is delivered to patients. In addition, she was your line manager and responsible for completing your probation report.

The panel noted Witness 2, in the Action Plan Meeting dated 11 November 2022 stated:

*'After the action plan was presented Mollie question about her medication management was she thought she was already signed off as she was been doing the medication and she wasn't done any mistakes. Sr. Tatiana explained that last meeting a drug error was were a treatment dose of tinzaparin was missed...'*

In the Action Plan Meeting dated 11 November 2022 it noted your explanation you gave in this meeting:

*'...Mollie explained that she escalated the situation to the doctor as she didn't thought the dose was correct and asked the doctor to change it. However, there was no documentation of this on nervecentre or on the medical notes and the dose was missed.*

*Mollie understood that this was a mistake...'*

The panel noted that Witness 2 had investigated the matter close to the time of the incident and found screenshot of this unknown patient's record which showed that

medication was not administered. It noted that this was brought to your attention in the meeting on 11 November 2022 where you acknowledged that you had not recorded it but had escalated it to a doctor as you believed it was the wrong dose. You had also accepted that you had not recorded it on the unknown patient's notes.

The panel took into account Witness 2's oral evidence where she stated:

*'She recognised her mistake and didn't feel supported'.*

In your oral evidence you disputed that this was your patient. You told the panel that you do not remember dealing with this unknown patient and do not remember escalating it to the doctor.

The panel considered the MAR chart dated 29 October 2022, a screenshot of the Electronic Prescribing Administration System (Nerve Centre), which shows that administration of Tinzaparin was missed on 1 November 2022. It noted that it cannot be certain from the screenshot whether or not this was your patient.

The panel determined that Witness 2 has been consistent in her evidence throughout whereas your account has changed significantly from 11 November 2022 to now and is inconsistent.

The panel determined that on the balance of probability it is more likely than not that this did happen and therefore, found charges 5a and 5b proved.

### **Charge 6(a)**

6) On 22 November 2022:

- a) Did not conduct checks of your allocated patients, at the commencement of the shift. Did not make enquiries, adequately or at all, in respect of Patient A3's chest drain at handover.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 7.

Witness 7 was the nurse in charge of the shift and was responsible for overseeing the teams on the Ward. This consisted of allocating staff to patients, offering support with their patients throughout the shift and also carry out general nursing duties. She was also supervising you during the shift.

The panel noted Witness 7 in her local statement dated 22 November 2022 stated:

*'While received handover, RN M. did not enquire about any details regarding the information's she received, eg. Was handed over that her patient has a chest drain in side room 5, no more information was seek... RN M. did not check on her patients, assessing how stable they were. Highlighted to M. that it was mandatory she would do that every time she begins a shift, in order to maintain patient's safety...'*

Witness 7 reiterates this in her NMC witness statement:

*'...Furthermore, Miss Nabitaka should have checked on all her patients straight after the handover to ensure that they were stable...'*

This is also consistent with Witness 7's oral evidence.

In your oral evidence you stated, *'I don't recall this patient or this shift'*.

The panel determined that Witness 7 was consistent in her evidence throughout and on the balance of probability it is more likely than not that this occurred and therefore finds charge 6a proved.

### **Charge 6(b)**

6) On 22 November 2022:

b) Did not timeously commence a drug round.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 7.

The panel noted Witness 7 in her local statement dated 22 November 2022 stated:

*'...She started trying to log in on nervecentre in the ipad. She did this between the staff room and the computer in Bay 5, taking 25 minutes in this process. She then informed me she could not access her log in and had to call IT. I had a look at what was being done and managed to log in with her details inserted. Then, RN M. informed me she did not have any trolley keys, to which I prompted her to find a set, which she did. Then she could not find a trolley, without looking first. At 08:30 RN M. started her morning drug round. I advised M. this could not happen every day, she had received handover over an hour ago, and was only then about to start drug round...'*

Witness 7 reiterated this in her NMC witness statement and in her oral evidence.

During cross-examination you said you did not have a problem with logging in, and you do not agree that it took an hour. You also said that you do not recall being late with the medication round.

The panel preferred Witness 7's evidence and determined that she was consistent throughout and therefore found charge 6b proved.

### **Charge 6(c)**

6) On 22 November 2022:

c) Did not timeously prepare Patient A4's oxygen venturi mask.

### **This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 7.

The panel noted Witness 7 in her local statement dated 22 November 2022 stated:

*'...It took RN M. 15 minutes to prepare a venture mask and increase the patient's oxygen...'*

Witness 7 further explains this in her NMC witness statement:

*'...Furthermore, it took Miss Nabitaka 15 minutes to prepare a venturi mask and increase Patient A4's oxygen which should take a minute for a RN to prepare. I informed a Doctor, although I cannot recall who, of Patient A4's observations to assist with Miss Nabitaka, although this was her responsibility. I do not recall any harm being caused to Patient A4 as a result of this incident.'*

Witness 7 reiterates this in her oral evidence and explains 15 minutes to prepare a venturi mask is too long.

In your oral evidence you told the panel that you do not recall this patient, and it should not take 15 minutes to prepare a venturi mask.

The panel preferred Witness 7's evidence and determined that she was consistent throughout and therefore found charge 6c proved.

### **Charge 7(a-b)**

7) On 1 December 2022:

- b) Did not provide an adequate handover of your allocated patients' diagnoses and/or treatment upon receiving a request for this information from Colleague A.
- c) Did not conduct checks of your allocated patients, at the commencement of the shift.

**These charges are found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 7.

The panel noted Witness 7 in her local statement dated 22 November 2022 stated:

*'...The handover was very dragging, with information that is not relevant to the nurse in charge, so I asked M. to tell me the most important information about her patients diagnosis and current medical treatment.*

*Straight after receiving handover M. did not check on her patients, as I had alerted her to do so before..."*

Witness 7 goes into detail in her NMC witness statement and further reiterates this in her oral evidence.

You told the panel that you do not have a recollection of this incident.

The panel accepts that you gave information during the handover, however they were not relevant to the patient's current treatment. It determined that Witness 7 was consistent in her evidence throughout and therefore finds charges 7a and 7b proved.

### **Charge 8**

- 8) On 6 July 2023 did not conduct Patient A's water flush and/or PEG feed at 08:00, as prescribed.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 8.

Witness 8 is a Senior Registered Nurse. Her role primarily involves the responsibility of looking after patients allocated to the team. When she is the nurse in charge on shift, she is responsible for overseeing patient care, staff management and day to day operations on the Ward, such as patient discharges. On the day in question, she was the nurse in charge of the day shift.

The panel noted Witness 8, in her local statement dated 17 July 2023 stated:

*'During the handover from the Night Staff it was clearly verbally stated that the patient in bed F2 had a PEG insitu and required his PEG feed and water flushes to be given at 8am, also clearly documented in the*

*Dietician PEG regime. MN listened to that verbal information because she asked what type of feed was due to start.*

*At approximately 9:45hrs one of the HCA's working in T3 came to me to say that the patient in bed F2 wanted to speak to me to make a complaint.*

*The patient was very angry and upset when I spoke to him- he said he had asked the Nurse (MN) if he could have his water flush and feed started as it was nearly 2 hours late. He said that he had asked her several times and she just kept saying in a minute and said to her that he can't just have a drink of water when he's dry he has to rely on the nurse to administer the water via his PEG.'*

Witness 8 reiterated this in her oral evidence.

In your oral evidence you told the panel that exhibit CB3, namely, the printout of the nervecentre dated 6 July 2023, you do not believe to be Patient A's record, and you raised questions around what that document is.

You told the panel:

*'I don't recall this patient. I can't remember. There are inconsistencies in this chart. The dietician's prescription is 83ml per hour. The chart shows 200ml. It's a different patient.'*

The panel considered Witness 8's local statement and noted that information around PEG feed for Patient A was given at handover for that shift. It noted that Patient A had made a complaint to say that they did not receive their PEG feed. Although there is evidence from the printout from the nervecentre, the panel are not relying on this as there are some inconsistencies with that and therefore unsure whether this document relates to Patient A.

The nervecentre printout suggests that you administered the fluids, but it does not establish it was administered to the patient who is identified by Witness 8 in her report.

The panel found Witness 8's evidence to be reliable and her local statement provided contemporaneous evidence of the incident and therefore finds charge 8 proved.

### **Charge 9(a-b)**

9) On 28 July 2023:

- a) Did not timeously complete Patient H's Electrocardiogram ("ECG").
- b) Inappropriately left disused plastic electrodes in Patient H's bed, following the ECG procedure at charge 9a).

### **These charges are found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 4/Colleague B, Witness 6, and Witness 2.

Witness 4/Colleague B was a Healthcare Assistant (HCA), and her role was to look after the patients allocated to the team she was assigned to for her shift. This involved carrying out their personal hygiene routine, Electrocardiogram (ECG) checks, bladder scans, escalating deteriorating patients and reporting changes with the patients' skin to the Nurses and/or Nurse in Charge.

When Witness 4/Colleague B was cross-examined by Ms Bennett, it was put to her whether you were treated differently because you are black. The panel did not see any evidence of this. On the contrary, the panel was satisfied that the witness's concerns were genuinely motivated by issues arising from your clinical practice and for patient safety.

The panel noted Witness 4/Colleague B in her local statement dated 28 July 2023 stated:

*'...Mollie came and she said she is going to do the ECG for B4 where she was using cardiac monitor tabs for ECG, then she found the right stickers for ECG, so she done the ECG in more than half an hour and then she started her medications...'*

Witness 4/Colleague B reiterates this in her NMC witness statement:

*'Despite Miss Nabitaka having all of the ECG equipment at Patient H's bedside, the procedure took longer than usual. Miss Nabitaka began carrying out the ECG with the incorrect electrodes, which are used for cardiac monitors. Although I do not recall the name of the stickers to be used with the ECG, I informed Miss Nabitaka of this and she replaced the electrodes with the correct ECG electrodes and continued to carry out the ECG on Patient H.'*

Witness 4/Colleague B was consistent in her oral evidence and was very clear and detailed in what had happened. When she was asked by Mr Soliman during her oral evidence about how long it took you to do the ECG, she explained that personal care for one patient takes 20 minutes and she had done four patients and you had not yet finished so she went to look for you.

The panel noted Witness 2 in her NMC witness statement stated:

*'...Colleague B...detailed concerns regarding Miss Nabitaka's time management. For example, Miss Nabitaka took more than 30 minutes to complete an electrocardiogram ("ECG")...'*

In your oral evidence you told the panel that you cannot recall this incident, but you would not take that long as it normally takes you 10 minutes.

Witness 4/Colleague B, with regard to the disused plastic electrodes, in her NMC witness statement stated:

*'When Miss Nabitaka had finished with Patient H and left to start her medication rounds, myself and [Ms 1] checked on the patients in B bay and we noticed that on Patient H's bed the electrodes that are plastic had come off of the old cardiac monitor tabs and been left on the bed...The plastic coming off the stickers had sharp edges and increased the risk of causing skin damage by cutting and tearing the skin. I did verbally raise my concerns to Miss Nabitaka but she was dismissive and she made excuses that she was busy...'*

Witness 4/Colleague B was consistent in her oral evidence as she explained that there is a risk that the plastic electrodes could cause to elderly patients due to their skin being thin.

In your oral evidence you told the panel that you do not recall this patient or the incident. You told the panel that the plastic electrodes do not have sharp edges and that you always dispose of them.

The panel considered Patient H's ECG, which shows ECG was taken of Patient H and that it was done by you, and this was printed out at 08:27.

The panel recognised that it was inappropriate of you to leave plastic electrodes in Patient H's bed. As raised by Witness 6, this patient had fragile skin and was bedbound, therefore leaving anything in the bed that can cause friction to the skin can put the patient at risk of harm.

The panel determined that both Witness 4/Colleague B and Witness 6 were clear and consistent in their evidence throughout and therefore found charges 9a and 9b proved on the balance of probabilities.

## Charge 9(c)

9) On 28 July 2023:

- c) Inappropriately shouted at Colleague B on receiving his suggestion that Patient N be tested for Coronavirus-19.

### **This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 4/Colleague B.

The panel noted Witness 4/Colleague B in her local statement dated 28 July 2023 stated:

*'...I said to Mollie I think we should inform to in charge because patient has new cough and high temperature...'*

Witness 4/Colleague B reiterates this in her NMC witness statement.

Witness 4/Colleague B in her oral evidence told the panel that, *'her voice was raised in a strongly way, it was angry, not professional'*.

In your oral evidence you denied shouting at Witness 4/Colleague B and told the panel, *'I never shouted at my colleagues'*. You told the panel that you remember the incident and the patient having covid and that you had thanked Witness 4/Colleague B afterwards.

The panel noted that Witness 4/Colleague B had taken these concerns to Witness 6 who had asked her to write a statement about what had happened.

The panel preferred the evidence of Witness 4/Colleague B, in that she was consistent in her evidence throughout, and the fact that she felt she needed to tell her supervisor about what had happened.

Accordingly, the panel found charge 9c proved on the balance of probabilities.

**Charge 9(d-e)**

9) On 28 July 2023:

- d) Did not respond to and/or ignored Patient O who was pressing their buzzer for assistance.
- e) Inappropriately refused to assist Colleague C with cleaning Patient O.

**These charges are found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 4/Colleague B.

The panel noted Witness 4/Colleague B in her local statement dated 28 July 2023 stated:

*'...side room 3 was pressing the buzzer, Mollie was walking up and down in ward but she was ignoring the buzzer...'*

Witness 4/Colleague B reiterates this in her NMC witness statement and oral evidence.

You told the panel that you cannot recall this and stated, *'I always respond to buzzers, I would never ignore a patient.'*

The panel noted Witness 4/Colleague B in her local statement stated:

*'...because patient was bedbound so he needs 2 people to clean so Rebecca went to Mollie and asked her to give her hand but Mollie refused and said she needs to do dressing...'*

Witness 4/Colleague B reiterates this in NMC witness statement and also clarified this in her oral evidence.

You told the panel that you were treating another patient at the time but the nurse in charge intervened and told you to go and assist with Patient O and so you did.

The panel noted that you went to assist with Patient O but only after the nurse in charge was made aware of your refusal by the HCA and therefore had to intervene.

The panel preferred the evidence of Witness 4/Colleague B, in that she was consistent throughout her evidence and her concerns were similar to the concerns raised by other staff members and therefore feel her evidence is more credible than yours.

The panel determined that on the balance of probabilities it is more likely than not that this had happened as it is a reoccurring theme and therefore finds charges 9d and 9e proved.

### **Charge 9(f)**

9) On 28 July 2023:

- f) Inappropriately shouted at Colleague B on receiving a request to monitor a bay while he took Patient P to the toilet.

### **This charge is found proved.**

In this charge the panel noted that the '*he*' is taking to say '*she*' as Colleague B is Witness 4.

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 4/Colleague B.

The panel noted Witness 4/Colleague B in her local statement dated 28 July 2023 stated:

*'...I asked her to keep an eye on bay watch, because I was going with patient to toilet, at that time there were 2 visitors next to A2 and she (Mollie) start shouting at me so loudly...'*

Witness 4/Colleague B, in her oral evidence explained to the panel that *'she was angry and shouted at me and it was said in front of patients and visitors. Visitors looked at me in shock.'*

You told the panel that you cannot recall this incident and stated, *"I would not shout at colleagues, I would not shout at anybody."*

The panel preferred the evidence of Witness 4/Colleague B and noted that there appears to be a pattern on this day of you shouting at Witness 4/Colleague B. The panel determined that this was inappropriate behaviour as it was done in front of patients and visitors and in any event.

Accordingly, the panel found charge 9f proved.

### **Charge 9(g)**

9) On 28 July 2023:

g) Inappropriately directed that Patient R's food tray be taken away, without first trying to encourage and/or assist them to eat.

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 4/Colleague B.

The panel noted Witness 4/Colleague B in her local statement dated 28 July 2023 stated:

*'I was in toilet with patient dinner was served A1 was little bit confused she said she doesn't want food Mollie said to [staff member] take it back she haven't (sic) encouraged patient even a single time...'*

Witness 4/Colleague B reiterates this in her NMC witness statement.

Witness 4/Colleague B in her oral evidence, contradicted this, as when she was specifically asked about what she had witnessed, she told the panel that she did not see the food being delivered or being taken away.

You told the panel that you cannot recall this incident and so cannot give an explanation, however you said, *"I always assist patients with feeding and monitor their intake"*.

The panel noted that there is conflicting evidence in that Witness 4/Colleague B's oral evidence is not consistent with her local statement and NMC witness statement, as Witness 4/Colleague B did not see you either encourage or not encourage the patient to eat.

The panel determined that there is no evidence that you did not try first encouraging and/or assist the patient to eat. Therefore, on the balance of probabilities, it is more likely than not that this did not happen.

Accordingly, the panel found charge 9g not proved.

### **Charge 9(h)**

9) On 28 July 2023:

h) Did not update and/or sign Patient J's Essential Care Record ("ECR").

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 6 and Patient J's Essential Care Record (ECR), dated 28 July 2023.

The panel noted that Patient J's ECR does not contain your signature. It noted that Witness 6 had gone to check on your patients and their records following complaints from staff and this is what she had found. This is consistent with her NMC witness statement.

Witness 6 in her oral evidence told the panel that she would expect to see a nurse's signature on the ECR at least twice a day. The panel noted that Witness 6 had also raised these issues in a probationary meeting.

You accepted that your signature is not on there albeit you cannot say whether this is your patient or not.

The panel preferred Witness 6's evidence and determined that on the balance of probabilities it is more likely than not that this is one of your patients, and this document shows no entry made by you.

Accordingly, the panel found charge 9h proved.

### **Charge 9(i)**

9) On 28 July 2023:

- i) Did not administer Patient K's Cetraben cream at 18:00, as prescribed.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 6 and the screenshot of the Nerve Centre for Patient K.

The panel noted that the screenshot shows that the Cetraben cream needs to be administered morning and evening. The panel surmise that the evening is around 18:00hrs and on 28 July 2023 the evening dose was missed.

The panel noted that this was brought to Witness 6's attention by the nightshift who had seen there was a missed dose and that was made at 22:00hrs.

You accepted that you may not have administered the cream, but also said that it was possible that you may have. You apologised for not documenting it.

The panel found Witness 6 to be consistent in her evidence and determined that on the balance of probabilities it is more likely than not that you did not administer the cream at 18:00 as prescribed.

Accordingly, the panel found charge 9i proved.

### **Charge 9(j)**

9) On 28 July 2023:

j) Did not assist colleagues to reposition Patient K and/or Patient L.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 6, Patient K's ECR dated 28 July 2023 and Patient L's ECR dated 28 July 2023.

The panel noted Witness 6 in her NMC witness statement stated:

*'...The ECR for Patient K also shows that Miss Nabitaka did not assist with the HCAs in repositioning them as she did not sign for any of these*

*checks. If two members of staff attend a patient, both the initials of staff should be recorded on the ECR chart when tasks are completed. The checks were completed by the HCA and a Student Nurse. I can confirm Miss Nabitaka did not sign the ECR to confirm the checks...*

*...The ECR for Patient L also shows that Miss Nabitaka did not assist with the HCAs in repositioning them as she did not sign for any of these checks...'*

Witness 6 also documented this in the Management Record dated 21 August 2023.

You accepted that the ECR charts do not contain your signature. However, you told the panel that you do not think that these were your patients.

The panel accepted the evidence of Witness 6 to be reliable, who had gone and investigated these patients' records following complaints from staff about you not assisting. Therefore, it determined that on the balance of probabilities it is more likely than not that you did not assist colleagues to reposition Patient K and Patient L.

Accordingly, the panel found charge 9j proved.

### **Charge 9(k)**

9) On 28 July 2023:

k) Did not administer Metformin to Patient L between 17:00 and 18:00, as prescribed.

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 6 and the screenshot of the Nerve Centre for Patient L.

The panel noted Witness 6 in her NMC witness statement stated:

*'Patient L was prescribed Metformin 500mg tablets once a day during the morning and once a day during the evening through his PEG tube. This record shows that Miss Nabitaka missed administering Patient L's evening prescription. This should have been administered between 17:00 and 18:00...'*

The panel relied on the evidence from Witness 6 and Patient L's Essential Care Record and Prescription, which shows a prescription for Metformin 500mg tablets for morning and evening. It noted that this document does not specify a time in which it needs to be administered and it shows that you administered the medication at 18:46. It noted that there are differing times on the screenshot from other members of staff for when the medication was administered which comes down to the fact that there is nothing to say it needs to be prescribed between 17:00 and 18:00. Therefore, it determined that you did administer the medication at the right time.

Accordingly, the panel found charge 9k not proved.

### **Charge 9(l)**

9) On 28 July 2023:

l) Did not administer Bisoprolol to Patient H at 08:00, as prescribed.

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 6 and the screenshot of the Nerve Centre for Patient H.

The panel noted that Witness 6 in the NMC witness statement stated:

*'Patient H was prescribed Bisoprolol 1.25mg tablets to be taken orally once a day. this record shows that Patient H was due this prescription at 08:00 but that Miss Nabitaka did not administer it until 13:11...'*

You explained to the panel that these tablets relate to blood pressure and that blood pressure readings have to be taken first before the tablets can be administered. It appears on the documentation that you did take blood pressure reading prior to administering medication at 13:11.

The panel took into account Witness 6's evidence however it noted that Patient H's prescription chart, dated 28 July 2023, is incomplete as there appears to be a blood pressure reading at 10:41. Given that the blood pressure reading is incomplete, it could be that medication administration was inappropriate at that time. It noted that the prescription does not state a time when the tablet should be administered, just says '*morning*'.

The panel determined that the evidence provided by the NMC is not enough to substantiate that you had deprived Patient H from medication, and there is no evidence that it needed to be administered at 08:00.

The panel preferred your explanation in your oral evidence and therefore finds charge 9I not proved.

### **Charge 9(m)**

9) On 28 July 2023:

m) Left medication unattended on Patient R's bedside table.

**This charge is found proved.**

In reaching this decision, the panel took into account the oral and documentary evidence of Witness 4/Colleague B.

The panel noted that Witness 4/Colleague B in the NMC witness statement stated:

*'...Miss Nabitaka tried to give medication to Patient R but she refused, and so Miss Nabitaka left Patient R's medication on the side table next to their bed with no water or glass. I am not aware of what this medication was as it is not within my role to administer medication. Patient R's daughters then turned up to visit Patient R and noticed there was no water and that the medication was just left on the side. When Patient R's daughters left, they left a handwritten note on Patient R's bedside which said not to leave medication unattended and that there was no water when they arrived...'*

Witness 4/Colleague B had taken this complaint to Witness 6, who informed you of that and gave you advice on leaving medication unattended. This was noted in the Management Record, dated 21 August 2023.

You told the panel that you do not recall this incident and that you would never leave medication unattended. You questioned where the handwritten note is and that this information was not shared with you.

The panel preferred Witness 4/Colleague B and 6's evidence and determined that on the balance of probabilities it is more likely than not that this did occur. Therefore, the panel found charge 9m proved.

### **Charge 10**

On a date unknown, inappropriately shouted at Colleague B in response to her request for assistance in feeding a patient.

**This charge is found proved.**

In reaching this decision, the panel took into account Witness 4/Colleague B's written statement and oral evidence, your oral evidence, and Witness 6's written statement and oral evidence.

Witness 4/Colleague B, in her witness statement, outlined:

*'I simply asked Miss Nabitaka to encourage one of the patients to eat when doing their medications and Patient PT's visitor stood up and said "stop shouting in front of the patients." Patient PT's visitor asked me if I was okay, to which I replied I was fine. I understand that Patient PT's visitor made a complaint verbally to one of the Nurses in Charge although I cannot recall specifically who, about this incident. I am aware of this complaint from staff talking generally on the Ward that Patient PT's visitor was a member of the Care Quality Commission ("CQC") and verbalised her concerns. I did not make a complaint about this incident because it was an isolated incident at that time.'*

The panel was of the view that Witness 4/Colleague B's account was credible. She was consistent throughout her oral evidence, and her oral evidence did not contradict her written statement. Witness 4/Colleague B escalated the incident to her manager. The incident was very specific, and Witness 4/Colleague B was able to consistently recall the incident in her oral evidence. The panel therefore preferred Witness 4/Colleague B's evidence.

In the Trust Management Record, dated 21 August 2023, Witness 6 mentioned that she gave you feedback letting you know that there were complaints against you.

In your oral evidence, you stated:

*“I do not recall. I always assist and I do not see it as a problem [to assist feeding patients].”*

In light of the evidence and the above, the panel determined that, on the balance of probabilities, it is more likely than not that you shouted at Colleague B in response to her request for assistance in feeding a patient. Charge 10 is therefore found proved.

### **Charge 11**

On a date unknown, had to be prompted to refrain from administering medication to an unknown patient as it would amount to an overdose.

**This charge is found proved.**

In reaching this decision, the panel took into account Witness 4/Colleague B’s written statement and oral evidence and your oral evidence.

Witness 4/Colleague B’s written statement states:

*‘There was also an incident (on a date I cannot recall) where I noticed Miss Nabitaka going to give medication to a patient in B bay who had been swapped with a patient from A bay. A few minutes before, Miss Nabitaka got confused and possibly forgot that she had already administered this patients' medication when she was in A bay. I could not be certain whether this had happened on a previous occasion to this or whether this had happened again after this occasion. I verbally raised this with Miss Nabitaka who was shocked about what she was about to do. Miss Nabitaka apologised to me and she seems grateful for me noticing. Had I not of told her that this medication had already been given, the wrong medication would have been administered. I did not document anything in relation to this incident because Miss Nabitaka proceeded to give the right medication to the right patient so no actual harm was caused.’*

In your oral evidence, you told the panel that “*you do not remember*” and “*do not recall*” this incident.

The panel was of the view that Witness 4/Colleague B’s evidence is cogent and consistent. It noted that medication administration has been a consistent concern in this case. As such, the panel determined that, on the balance of probabilities, it is more likely than not that you had to be prompted to refrain from administering medication to an unknown patient as it would amount to an overdose. Charge 11 is therefore found proved.

## **Charge 12**

On 21 August 2023:

- a) Did not administer Patient B’s insulin at 08:00, as prescribed.
- b) Did not administer Patient C’s insulin at 08:00, as prescribed.
- c) Did not demonstrate awareness of the possible side-effects of administering insulin after the prescribed time.
- d) Inappropriately refused to assist Colleague D with washing patients and/or conducting observations.
- e) Did not timeously check Patient A2’s blood pressure.
- f) Did not timeously complete a drug round.
- g) Did not timeously check an unknown patient’s temperature.
- h) Did not administer Co-beneldopa to Patient M at the prescribed times of:
  - i. 08:00
  - ii. 12:00
  - iii. 16:00

**This charge is found proved in relation to sub charges a,b,c,e,f,g and h only.**

## **Charges 12(a) and 12(b):**

The panel took into account Witness 8's written statement and oral evidence, Witness 8's local statement, Nerve Centre screenshots, and your oral evidence.

The panel took into account Witness 8's written statement, which states:

*'During the handover from the night shift at approximately 07:00, it was verbalised by the HCAs that two specific patients were on a twice by day prescription of Insulin, who were Patient B and Patient C. [...] Upon review of [Patient C's routine diabetic chart], Patient B and Patient C should have been given their morning Insulin at 08:00 prior to them being given their breakfast. I understand that Patient A was also to be discharged that day with an ambulance collecting them at 09:00.'*

The panel also took into account Witness 8's local statement, dated 22 August 2023. The statement was made the day after the incident, and the panel is of the view that the statement is credible and consistent. The panel also considered the proximity to the incident that the statement was made, specifically that it was made the following day.

The panel noted that you challenged the data. The panel considered the Nerve Centre Electronic Patient Record screenshots, but noted that these were unclear, namely in relation to the screenshots and the routine diabetic chart exhibited by Witness 8, and determined that more information was needed to contextualise the information.

In your oral evidence, you told the panel *"I can't remember why it was given at those times."*

The panel preferred Witness 8's evidence. It was of the view that Witness 8's oral evidence was consistent and credible, and did not contradict her written statement or local statement.

The panel therefore determined that, on the balance of probabilities, it is more likely than not that you did not administer Patient B and Patient C's insulin at 8:00 as prescribed.

**Charge 12(c):**

The panel took into account Witness 8's local statement, dated 22 August 2023:

*'When I asked MN why [the insulin] hadn't been administered she said oh because they didn't eat much breakfast (their blood sugars were both in range) and the Insulin was prescribed to give on the Green Diabetic chart and on Nerve Centre. Again, she showed no awareness or remorse that these had been omitted and the possible consequences- she then said oh I'll just give now, I told her to speak to the doctor as we can't just give anytime it has to be re prescribed and blood sugars re checked.'*

In your oral evidence, you told the panel that you did not have this discussion with Witness 8. However, the panel preferred Witness 8's evidence and had sight of the Management record made by Witness 6.

The panel therefore determined that, on the balance of probabilities, it is more likely than not that you did not demonstrate awareness of the possible side-effects of administering insulin after the prescribed time.

**Charge 12(d):**

The panel took into account Witness 5/Colleague D's oral evidence and written statement, and your oral evidence.

The panel noted that both Witness 5/Colleague D's local statement and written statement accept that you refused to assist Witness 5/Colleague D with washing patients, as you went on to take a patient's blood pressure.

In your oral evidence, you told the panel that you did wash some patients, but then you went on to take the blood pressure of some other patients after.

The panel was satisfied that, factually, you did refuse to assist Witness 5/Colleague D in washing patients. However, when considering whether this refusal was inappropriate, the panel found that it was not inappropriate to refuse to assist washing patients in order to conduct important tasks such as taking blood pressure of patients.

As such, the panel found that the NMC has failed to discharge the burden of proof in relation to this sub charge, and finds it not proved.

### **Charge 12(e)**

The panel took into account the local statement from Witness 5/Colleague D, dated 21 August 2023, which outlines that it took you almost half an hour to check the patient's blood pressure. The panel noted that this was corroborated by Witness 5/Colleague D's written statement and oral evidence.

The panel also took into account that Witness 6 gave you feedback in relation to this and gave you advice.

The panel was of the view that Witness 5/Colleague D's evidence was credible and reliable evidence. Her oral evidence was consistent with her local statement and written statement.

As such, the panel determined that, on the balance of probabilities, it is more likely than not that you did not timeously check Patient A2's blood pressure.

### **Charge 12(f):**

The panel took into account Witness 5/Colleague D's local statement. It noted that she described that it took you a long time to complete the drug round:

*'Molly started medication at 7:45 am and didn't finish until 12:30 pm.'*

The panel noted that your time management appears to be a consistent issue which has been raised by multiple parties on various occasions.

Witness 6 stated that this issue was brought to her attention, and she had a conversation with you regarding the amount of time that the medication rounds took.

The panel was of the view that Witness 5/Colleague D's evidence was consistent and reliable. Her local statement, written statement, and oral evidence were consistent and not contradictory.

As such, the panel determined that, on the balance of probabilities, it is more likely than not that you did not timeously complete a drug round.

**Charge 12(g):**

The panel took into account Witness 5/Colleague D's written statement, which states:

*'I recall Miss Nabitaka taking 15 minutes to check a patient's temperature, although I cannot recall who this patient was. I felt as though Miss Nabitaka was prolonging carrying out simple tasks to avoid helping me with the patients' personal care as Miss Nabitaka knew I required assistance but did not help.'*

In your oral evidence, you said that you could "*not recall this*" incident, and that this [task] was "*very straightforward.*"

The panel was of the view that Witness 5/Colleague D's evidence was consistent and reliable. Her local statement, written statement, and oral evidence were consistent and not contradictory. The panel preferred Witness 5/Colleague D's evidence to yours.

The panel noted that this task, namely taking a patient's temperature, should take 1-2 minutes to carry out.

As such, the panel determined that, on the balance of probabilities, it is more likely than not that you did not timeously check an unknown patient's temperature.

**Charge 12(h):**

The panel took into account Witness 5/Colleague D's written statement and oral evidence.

In her written statement, Witness 5/Colleague D states:

*'Patient M was prescribed Co-beneldopa 25mg/100mg to be taken orally, four times a day, specifically at 08:00, 12:00, 16:00 and 20:00. Patient M had Parkinson's disease and Co-beneldopa is prescribed to treat and manage Patient M's symptoms. [...] Patient M's 08:00 prescription was given at 10:11, two hours later than it was due. [...] the 12:00 prescription was given at 12:57. [...] the 16:00 prescription was given at 18:29. Throughout the day, Patient M kept asking Miss Nabitaka for his medication. I knew that Miss Nabitaka was administering Patient M's medication late because I observed this during the day. I do not recall any impact to Patient M as a result of their delayed medication.'*

The panel took into account that Patient M's record shows that there are three entries made by you, showing late administration.

In your oral evidence, you said that you wrote these entries in the record retrospectively.

The panel, having heard the evidence from Witness 5/Colleague D and Witness 6, noted that there is a pattern of you being late to administer medication.

As such, the panel determined that, on the balance of probabilities, it is more likely than not that you did not administer Co-beneldopa to Patient M at the prescribed times of 08:00, 12:00, and 16:00.

### **Charge 13**

On 10 September 2023:

- a) Did not adhere to infection control procedure in that you used the same insulin pen on two or more patients.
- b) Did not conduct prescribed skin checks in respect of:
  - i. Patient T
  - ii. Patient U
  - iii. Patient V
  - iv. Patient W
  - v. Patient X

Or in the alternative did not record you had conducted the skin checks.

- c) Did not administer one or more of the medications at Schedule 1 to patients at the prescribed time.

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

### **Charge 13(a):**

The panel considered Witness 6's oral evidence and written statement and your oral evidence.

Witness 6 observed you making the mistake. In your oral evidence, you told the panel that you could not recall this incident.

The panel was of the view that Witness 6's evidence is consistent and reliable. Her written statement, and oral evidence were consistent and not contradictory. The panel preferred Witness 6's evidence to yours.

As such, the panel determined that, on the balance of probabilities, it is more likely than not that you did not adhere to infection control procedure in that you used the same insulin pen on two or more patients.

**Charge 13(b):**

The panel took into account Witness 5/Colleague D's written statement and oral evidence, Witness 6's written statement and oral evidence, and the patients' Essential Care Record.

Witness 6 had been approached by members of staff that day to inform her that you had not been conducting skin checks. You had not signed records to confirm whether the patients had their checks.

Witness 5/Colleague D's written statement states:

*'Furthermore, as Miss Nabitaka was the Registered Nurse, she was responsible for signing off the patients essential care records for the skin checks carried out whilst she was on shift, which must be completed in the morning, in the afternoon and in the evening. Although a HCA can carry out skin checks, a Nurse must confirm these checks and sign them off. Towards the end of the shift, I verbally reported my concerns to my Line Manager, (Ward Manager) who was also Miss Nabitaka's Line Manager. I did not have a chance to report my concerns during the day because I was very busy and I was also on the cohort bay the majority of the shift which meant that I could not leave F- bay. [My line manager] asked me to write a written complaint about Miss Nabitaka. At the end of the shift, I wrote a written complaint.'*

In your oral evidence, you said that you could not remember, and in relation to Patient T in particular, that there is no way of knowing whether this was you or not.

The panel preferred the evidence of Witness 6 and Witness 5/Colleague D. The evidence did not contradict the other, and the witnesses were reliable and consistent.

As such, the panel determined that, on the balance of probabilities, it is more likely than not that you did not record you had conducted the skin checks.

### **Charge 13(c):**

The panel took into account Witness 6's written statement and oral evidence, your oral evidence, and the patient records.

The panel took into account that the patient records were recorded by you retrospectively, as found proved in charge 13(h). The panel took into account that Witness 6's written statement and oral evidence recall concerns that you were not administering patient medications at the correct times, with these concerns being raised to her by staff members.

In your oral evidence, you said that you did administer the medications on time. However, the panel preferred Witness 6's evidence.

As such, the panel determined that, on the balance of probabilities, it is more likely than not that you did not administer one or more of the medications at Schedule 1 to patients at the prescribed time.

### **Decision and reasons on lack of competence**

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 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 ability to practise safely and effectively without restriction.

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 practice.'*

Mr Soliman 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 NMC code of professional conduct: standards for conduct, performance and ethics' ("the Code") in making its decision.

Mr Soliman identified the specific, relevant standards where your actions amounted to a lack of competence. He submitted that lack of competency needs to be assessed using a three stage process:

- Is there evidence that you were made aware of the issues around your competence?
- Is there evidence that you were given the opportunity to improve?
- Is there evidence of further assessment?

Mr Soliman submitted that the facts found proved show that your competence at the time was below the standard expected of a band 5 registered nurse.

You told the panel that you are a competent nurse. You told the panel that your employer was going to 'get rid of you' regardless of your ability to practice safely and without error. You told the panel that you did not feel supported and that you were under pressure on the ward.

### **Submissions on impairment**

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

Mr Soliman submitted that your practice is impaired by way of your lack of competence. He submitted that the charges found proved put patients at an unwarranted risk of harm, including poor medication administration, not timeously recording patient data, observations, and late entries into patient records.

Mr Soliman submitted that a finding of impairment is necessary to protect the public from a risk of harm. He submitted that a finding of impairment is also in the public interest, as a

member of the public would be concerned if a nurse with multiple concerns around their practice were allowed to practice without a finding of impairment.

You told you panel that you have provided a letter and a training certificate demonstrating evidence of your strengthened practice. You told the panel that you do not accept that you made errors. You told the panel that your practice is not impaired.

The panel accepted the advice of the legal assessor, who referred it to the cases of *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin), *Holton v General Medical Council* [2006] EWHC 2960 (Admin), *Grant* (above), and *Cohen v General Medical Council* [2007] EWHC 581 (Admin).

### **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, the following standards:

- ‘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*
  
- 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*
- 2.6 recognise when people are anxious or in distress and respond compassionately and politely*
  
- 6.2 maintain the knowledge and skills you need for safe and effective practice*

- 8.1 *respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
- 8.2 *maintain effective communication with colleagues*
- 8.3 *keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
- 8.5 *work with colleagues to preserve the safety of those receiving care*
- 8.6 *share information to identify and reduce risk*
  
- 9.2 *gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*
  
- 10.1 *complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
- 10.3 *complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
  
- 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*
  
- 14.1 *act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm*
- 14.2 *explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers*
  
- 18.1 *prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs*

- 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*
- 19.3 *keep to and promote recommended practice in relation to controlling and preventing infection*
- 19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*
- 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 a competent Band 5 registered nurse and not by any higher or more demanding standard.

The panel took into account that you were to meet probationary objectives on Ward 10, and it accepted that this ward had patients with complex needs, and was likely to be demanding for a newly qualified nurse. However, the panel was of the view that you were provided support on this ward, and you had a number of reviews where you were given supernumerary status while working alongside staff. When you were put on supernumerary status, you were not included in staffing numbers. You were afforded the opportunity to develop your skills and knowledge at your own pace whilst working alongside other people and experienced staff. You were given training, and your probation period was extended to allow you to achieve your action plan.

The panel also took into account that you were redeployed to Ward 15, which was less acute and less busy. You were given supernumerary shifts, and the panel accepts that there were no issues appearing within that first month. However, once you transitioned back into the staffing numbers, the same concerning themes reemerged, namely:

- Late administration of medication
- Unsafe practice when administering medication and insulin
- Late entries

- Several instances around timeously completing drug rounds
- Time management issues around patient observations taking too long and record keeping
- Not properly recording patient observations, with a large number of retrospective entries made in patient records.

The panel was of the view that over a period of 18 months, you were given plenty of support and training, and despite this support you were unable to reach the required standard of what is expected of a Band 5 nurse. While the panel accepted that there may have been an element of stress and pressure whilst you were going through extended probation, such a probationary period is necessary in order to create a safe practice for patients. Furthermore, the panel took into account that this was not an isolated incident of poor nursing practice, you demonstrated recurrent themes of lack of competence over an 8-month period.

Taking into account the reasons given by the panel for the findings of the facts, and in light of the above, the panel has concluded that your standard of professional performance was unacceptably low as demonstrated by reference to a fair sample of your work.

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 NMC Guidance on '*Impairment*' (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

*'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

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:

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

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

*'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/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.'*

The panel first considered the limbs of the Grant test, as set out above, in relation to 'in the past'. It was satisfied the first three limbs are engaged.

The panel found that patients were put at risk of physical harm as a result of your lack of competence. You administered Parkinsons and insulin medications late, you practised poor infection control around medication, and did not carry out patient observations in a timely manner. Your lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel took into account that, in some of the charges found proved, you were found to have shouted at health care professionals in front of patients. Additionally, your medication management errors were picked up and raised by the patients and family of the patients.

In considering whether you are liable to repeat the three limbs, a), b) and c), of the Test in the future, the panel considered your insight and remediation. The panel acknowledged that the areas of clinical competence which arise in this case can be remediated if you fully engage with reflecting and strengthening your practice. It also acknowledged that the charges took place over an extended period of time and the concerns are numerous.

The panel was of the view that you have not demonstrated strong insight into the recurrent themes which arose in your practice, and you have not demonstrated steps taken to address these themes and concerns. The panel accepted that you have found it difficult to secure a nursing role since leaving Bedfordshire NHS Foundation Trust. However, it was of the view that you could have applied for other roles within a healthcare setting.

The panel acknowledged that you have provided some evidence of training undertaken in 2022 and 2023, and demonstrated some limited insight into charge 13(b). However, you do not accept that you have made mistakes with regards to the remaining charges found proved. The panel was of the view that this training and limited insight was not sufficient to mitigate the risk of repetition.

The panel is of the view that there is a risk of repetition in light of all the above. 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 the 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. The panel determined that public confidence in the nursing profession would be undermined if a nurse with a pattern of lack of competence, over an extended period of time, were allowed to practice without a finding of impairment. It determined that a finding of impairment is necessary in order to uphold and declare proper standards of safe nursing practice, and uphold public confidence in the nursing profession and the NMC as its regulator.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

## **Sanction**

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 18 months, with a review. The effect of this order is 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.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on '*The sanctions available*' (Reference: SAN-2 Last Updated: 28/01/2026).

### **Submissions on sanction**

Mr Soliman informed the panel that in the Notice of Hearing, the NMC had advised you that it would seek the imposition of a conditions of practice order if it found your fitness to practise to be currently impaired.

Mr Soliman submitted that the appropriate and proportionate order is a conditions of practice order for a period of 2 years, with a review.

Mr Soliman submitted that the following aggravating features are present in this case:

- Conduct which breached fundamental tenets of nursing
- Plethora of concerns over an extended period
- Concerns which persisted over 18 months despite extensive support being given
- Patients placed at unwarranted risk of harm
- Workload of colleagues was increased by your inability to provide support to them
- Lack of insight
- Disputes allegations and demonstrates lack of personal accountability
- No evidence of remediation and not currently practising

Mr Soliman submitted that the following mitigating features are present in this case:

- You were a newly qualified nurse who only entered registration in March 2022. The

allegations arise only three months later

- Clinical concerns which are remediable
- [PRIVATE]
- You qualified during the Covid-19 pandemic
- You believed that there was a racist bias against you
- Gaps in your training and support
- Objectives set for you were not always clear and measurable

Mr Soliman submitted that you were given support, and your performance did not improve when you moved to a different ward. He submitted that this signals an entrenched lack of competence.

Mr Soliman submitted that you require significant development in order to remediate the deficiencies in your practice.

You told the panel that this was your first job, and that you would find it difficult to secure a nursing role if you were subject to a conditions of practice order for a period of 2 years. You told the panel that a 6-month conditions of practice order is preferable.

The panel accepted the advice of the legal assessor.

### **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. 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 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 breached numerous fundamental tenets of nursing

- Various clinical concerns over an extended period of time
- Concerns which persisted over 18 months despite extensive support being given
- Patients placed at unwarranted risk of harm
- Workload of colleagues was increased by your inability to provide support to them
- Lack of insight

The panel also took into account the following mitigating features:

- Undertaking of your nursing training occurred during the Covid-19 pandemic
- No evidence of attitudinal concerns
- Clinical competencies are remediable
- You were newly qualified at the time of the concerns

The panel first considered whether to take no action but concluded that this would be inappropriate in view of its finding of lack of competence and impairment, and the nature of the charges found proved which relate to multiple instances of poor clinical practice over an extended period of time. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel next considered a caution order and had regard to the NMC Guidance on 'Caution order' (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

*'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'*

The panel considered that your actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that

a sanction that does not restrict your practice would not protect the public. The panel also determined 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 appropriate. The panel had regard to the NMC Guidance on '*Conditions of practice order*' (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.'*

The panel took into account there is a realistic prospect that the areas of clinical concern can be addressed and mitigated through conditions. There is no evidence that you have deep-seated personality or attitudinal issues that would prevent you from adhering to conditions of practice. It was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

The panel accepted that you have had difficulty in securing employment in a nursing role while subject to your interim conditions of practice. However, the panel determined that, notwithstanding this, conditions would be workable, relevant, proportionate, and practicable in this case. Measurable conditions would address the failings highlighted in this case.

The panel was of the view that to impose a suspension order would be disproportionate and would not be a reasonable response in the circumstances of your case. As the concerns and impairment relates to your clinical practice and competence, a suspension order would not allow you to address the concerns and strengthen your practice. The panel did not find that your practice is fundamentally incompatible with remaining on the NMC register, and was of the view that it would not be in the public interest to suspend you. The panel also took into account that you have engaged with the NMC throughout these proceedings.

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

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

The panel determined that the following conditions are appropriate and proportionate in this case:

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

1. You must work for one substantive employer. If this is an agency, it must be for one employer.
2. You must ensure that you are supervised by another nurse in charge, or above, at 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 nurse in charge, or above.

3. You must send your NMC Case Officer a report from your line manager, mentor, or supervisor, 7 days in advance of the next hearing detailing your progress in the following areas of concern:
  - Competence in time management which includes timeous observation of patients, administration of medication to patients, medication rounds, and record keeping
  - Timeliness of record keeping

This report should be successfully completed in 18 months' time from the coming into effect of these conditions

4. You must work with your line manager, mentor, or supervisor to create a Personal Development Plan (PDP) which addresses the following concerns:
  - Competence in time management which includes timeous observation of patients, administration of medication to patients, medication rounds, and record keeping
  - Competence in record keeping
5. You must complete a reflective piece. This reflective piece must be signed by your line manager, mentor, or supervisor. This signed reflective piece must be sent to your NMC Case Officer within 7 days of the next review of your order.
6. You must keep the NMC informed about anywhere you are working by:
  - a) Telling your case officer within seven days of accepting or leaving any employment.

- b) Giving your case officer your employer's contact details.
7. You must keep the NMC informed about anywhere you are studying by:
- a) Telling your case officer within seven days of accepting any course of study.
  - b) Giving your case officer the name and contact details of the organisation offering that course of study.
8. You must immediately give a copy of these conditions to:
- a) Any organisation or person you work for.
  - b) Any employers you apply to for work (at the time of application).
  - c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
9. You must tell your case officer, within seven days of your becoming aware of:
- a) Any clinical incident you are involved in.
  - b) Any investigation started against you.
  - c) Any disciplinary proceedings taken against you.
10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
- a) 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 period of this order is for 18 months.

Before the order expires, a panel will hold a review hearing 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 confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Evidence of compliance with your conditions of practice order
- Your continued engagement at any future review hearing
- Copies of your reflective piece (see condition 6) provided to the NMC prior to any review

This will be confirmed to you in writing.

### **Submissions on interim order**

The panel took account of the submissions made by Mr Soliman. He outlined that there is a 28-day appeal period before the substantive order will take effect. If you were to appeal this decision, the substantive order will not come into effect until any other appeal period is over. Mr Soliman submitted that an interim order is therefore necessary to protect the public and meet the public interest during any period of appeal, for the reasons set out above in the panel's determination on sanction.

Mr Soliman submitted that an interim conditions of practice order is the appropriate and proportionate order.

You did not make any submissions in regards to this application.

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 facts found proved, its finding of lack of competence, 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 a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months in order to protect the public and meet the public interest during any period of appeal.

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 are sent the decision of this hearing in writing.

That concludes this determination.