# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**Tuesday, 5 March 2024 – Wednesday, 13 March 2024**
**Thursday, 17 October 2024- Friday, 18 October 2024**

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

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| **Name of Registrant:** | Elka Tzvetkova |
| **NMC PIN** | 11A0047C |
| **Part(s) of the register:** | Registered Nurse – Adult<br>Effective – 5 January 2011 |
| **Relevant Location:** | North Devon |
| **Type of case:** | Misconduct |
| **Panel members:** | Patricia Richardson (Chair, Lay member)<br>Mark Gibson (Registrant member)<br>Alyson Young (Lay member) |
| **Legal Assessor:** | Juliet Gibbon (5 March 2024 – 8 March 2024)<br>Oliver Wise (11 March 2024 – 13 March 2024<br>17 October 2024-21 October 2024) |
| **Hearings Coordinator:** | Amanda Ansah (5 March 2024- 13 March 2024)<br>Hanifah Choudhury (17 October 2024- 21 October 2024) |
| **Nursing and Midwifery Council:** | Represented by Sam March, Case Presenter (5 March 2024- 13 March 2024)<br>Debbie Churaman (17 October 2024- 21 October 2024) |
| **Ms Tzvetkova:** | Present and represented by Louisa Simpson, instructed by Royal College of Nursing, (RCN)<br>Not present at the hearing 17 October 2024- 21 October 2024 but represented by Louisa Simpson |
| **No case to answer:** | Charge 1b |

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| **Facts proved:** | Charge 1a and Charge 1c |
| **Fitness to practise:** | Impaired |
| **Sanction:** | **Conditions of practice order (12 months)** |
| **Interim order:** | **Interim conditions of practice order (18 months)** |

**Details of charges**

That you, a registered nurse:

1) On 9 July 2019, failed to:

    a) Administer and/or ensure administration of Phenytoin to Patient A.

    b) Administer the full dose of Sodium Valproate to Patient A.

    c) Escalate that Patient A had not received their full prescribed dose of Sodium Valproate.

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

**Decision and reasons on application to amend the charge**

The panel heard advice from the legal assessor that an application to amend the wording of charge 1b should be considered by the parties.

The proposed amendment was to change the way the charge currently reads to include the remainder of the dose of sodium valproate and make it clear to the reader what the full dose required is. It was suggested by the legal assessor that the proposed amendment would provide clarity not only to you, but to any member of the public reading this document.

*"That you, a registered nurse:*

*1. On 9 July 2019, failed to:*

b. *Administer ~~the full dose of Sodium Valproate to Patient A~~* ***the remainder of the dose of sodium valproate to Patient A, as only 200mg of the prescribed dose of 600mg had been administered.***

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

Mr March, on behalf of the Nursing and Midwifery Council (NMC) submitted that the amendment was not necessary as it is clear what charge 1b means as it currently reads. He further submitted that the mischief in the charge is clear given that the night shift nurse administered 200mg out of 600mg of sodium valproate as prescribed, so the duty fell on you following the handover, to either administer or ensure the administration of the remainder of that full dose. However, Mr March did not oppose the legal assessor's suggested amendment and acknowledged that the panel has the power to amend the charge of its own volition.

Ms Simpson, on your behalf, submitted that although the mischief is clear in relation to this charge, it is not currently written in a way that reflects what is understood to be the charge the NMC intends to pursue. She submitted that it is alleged you failed to administer the full dose, but it is known that part of this dose had already been administered. Therefore, there could not possibly be a responsibility on you to administer a full dose. Whilst in terms of fairness to you, it is understood what the NMC's case is on this charge, it is not currently written in a way that reflects this and greater clarity is needed.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment was in the interests of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. The panel noted that it was not the NMC's application to amend the charge in this way. However, it was

satisfied that making this amendment of its own volition would provide clarity and accurately reflect the evidence.

**Details of charges (as amended)**

That you, a registered nurse:

1) On 9 July 2019, failed to:

a) Administer and/or ensure administration of Phenytoin to Patient A.

b) Administer the remainder of the dose of sodium valproate to Patient A, as only 200mg of the prescribed dose of 600mg had been administered.

c) Escalate that Patient A had not received their full prescribed dose of Sodium Valproate.

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

**Background**

The charges arose whilst you were employed as an agency nurse by Red Nursing 24 (the Agency). You were working a bank shift on 8 July 2019 at King George V Ward (the Ward) at North Devon Hospital (the Hospital). The following information is based on the NMC's case against you and is not to be taken as any finding against you. The charges relate to a single incident in respect of the care of Patient A during this shift.

The charges concern an issue with the medication that was not administered to Patient A, an epileptic patient. Subsequently, Patient A suffered a short seizure then later a full seizure. It is suspected that the seizures were contributed to both by sepsis, and by your failure to administer the prescribed anti-epileptic medication.

Patient A was prescribed two types of anti-epileptic medication which together were aimed at reducing the risk of seizures. The first of these is Phenytoin, which was administered orally and Sodium Valproate, which was being given intravenously (IV).

You took over the care of Patient A on your first day on the ward as a Bank nurse and the night nurse, Witness 2, provided a handover. Shortly before you took over, Witness 2 had sought to administer Patient A's intravenous medication but was only able to administer 200mg of the 600mg due. This was because the cannula was painful and had tissued overnight, and Witness 2 was not trained to cannulate. As a result, Witness 2 made this part of her handover including the referral to the on-call doctors. Within the notes Witness 2 provided, she made it clear that this was a priority. At 08:55am, the doctors conducted their rounds and stated that Patient A could have a soft diet. At this point, Patient A's prescribed Phenytoin could have been given orally.

This medication however was not administered, and Patient A then had a small seizure. Patient A later suffered from a full seizure and required medical intervention. Subsequently, Patient A was cannulated, the medication was administered intravenously, and Patient A was eventually stabilised.

You were referred to the NMC on 23 August 2019 by the Clinical Complaints Team Lead at the Agency.

**Decision and reasons on application of no case to answer**

The panel considered an application from Ms Simpson that there is no case to answer in respect of all the charges. This application was made under Rules 24(7) and 24(8).

In relation to this application, Ms Simpson provided the following written submissions:

> *"…*
>
> *RE: Charge 1a*

7. *The NMC allege the Registrant failed on 09 July 2019 to administer and/or ensure administration of Phenytoin to Patient A.*

8. *The Panel will be aware that in order to find a charge proved which alleges a "failure" to do something, they must be satisfied both that there was a responsibility on the Registrant to do said thing, and that the Registrant did not do it. It is not disputed that the Registrant did not administer or ensure the administration of Phenytoin to Patient A on 09 July 2019. However, it is submitted there is insufficient evidence for a Panel to conclude there was a responsibility on her to administer it (or ensure its administration).*

9. *On the NMC's own evidence, the Phenytoin was a 6am drug as can be seen from the drugs chart [**78**]. The Registrant's shift began at 7am. There has been inconsistent evidence from the NMC witnesses as to when this medication should have been given, and whose responsibility it was to administer. [Witness 1] told the Panel all IV medication was given overnight, and all oral medication was given by the day shift – because they did not want to wake the patients in the night to give oral medications. [Witness 2] told the Panel in evidence that all IV medications were given overnight, but so were some oral medications – controlled drugs, and pain relief if requested. [Witness 2] explained the reasoning in fact to be that night staff had more patients and so could not administer all 6am medications to their patients in time. [Witness 3] then explained to the Panel a third understanding of which medications were given when, and stated that as well as all IV medications, oral controlled drugs and pain relief if requested, any 6am medication requested by the patient could be given by the night staff.*

10. *There is no documented evidence that it was the policy or practice of this ward for the day staff to administer any 6am medications on their shift, at 8am. No NMC witness has been able to indicate or*

*confirm whether or not this is documented at all – certainly the Panel have not had sight of any such written policy. It is submitted no such policy exists, as even the NMC witnesses who had each worked on the ward a number of years had different understandings as to how the policy apparently worked in practice.*

11. *[Witness 2]'s evidence was that Patient A was awake early **[para 6]** and she recalled orally in evidence that she had administered some pain relief to [them] that morning, as [they] had requested it. If the reason for not administering 6am medication is, as [Witness 1] said, not to wake the patient, this would indicate the 6am Phenytoin could and should have been administered by [Witness 2]. The fact it was [Witness 2] who should have administered the Phenytoin intravenously is reinforced by the fact Patient A had vomited a number of [their] other oral medications given on 07, 08 and 09 July 2019 (as indicated by the code "6" on the drugs chart) [**78**].*

12. *It is also indicated on the drugs chart that the Phenytoin could be administered either orally "PO" ("Per Oral"), or intravenously ("IV") [**78**]. [Witness 2] could not be sure whether the Phenytoin was available in an IV or oral format. If IV, as prescribed, on all NMC witnesses' evidence, it should have been administered by [Witness 2] on the night shift, and was not the Registrant's responsibility.*

13. *Further or alternatively, as of 07 July 2019, Patient A was nil by mouth, as can be seen on the drugs chart against the Gabapentin and/or Sodium Valproate ("NBM") [**78**]. It is submitted as a matter of common sense that if a patient is Nil By Mouth in respect of one medication they must be entirely nil by mouth and cannot receive anything orally. Therefore even if the Phenytoin was only available orally and not via IV, the Registrant could not have administered it in any event. There is no evidence the doctors' entry on 09 July*

*2019 at 08:55 "1) start soft diet" was raised with or flagged to the Registrant, and if so when it was [**19**].*

14. *Accordingly, it is submitted there is no case to answer as to the facts of Charge 1a.*

*<u>RE: Charge 1b</u>*

15. *The NMC allege the Registrant failed on 09 July 2019 to administer the remaining dose of Sodium Valproate to Patient A.*

16. *Again, in order to find this charge proved the Panel must be satisfied there was a responsibility on the Registrant to administer the remaining dose of Sodium Valproate, as well as the fact that she did not administer it. It is not disputed the Registrant did not administer the full dose of Sodium Valproate to Patient A on 09 July 2019. However, it is submitted there is insufficient evidence for a Panel to conclude there was a responsibility on her to administer it.*

17. *The Registrant could not physically have administered the Sodium Valproate to Patient A, as it was an IV medication only, and Patient A had no route to receive any IV medication. The NMC witnesses state his cannula had tissued and been removed. Cannulation requires an additional course/qualification, which the Registrant had not completed, and so she could not re-cannulate Patient A herself. She therefore could not administer the full or remaining dose of Sodium Valproate. There cannot have been a duty on her to administer medication when it was not possible to do so.*

18. *Accordingly, it is submitted there is no case to answer as to the facts of Charge 1b.*

*RE: Charge 1c*

19. *The NMC allege the Registrant failed on 09 July 2019 to escalate that Patient A had not received their full prescribed dose of Sodium Valproate.*

20. *The Registrant's evidence has consistently been that she did refer this Patient to the medical/surgical team of doctors, but they did not follow-up. She states this in her relatively contemporaneous statement of 27 October 2019 [**97**] and in her first response to the NMC [**102**]. [Witness 2] agreed in cross examination that she would not ordinarily expect to see documentation of any escalation to other or more senior nursing staff – so it may well have happened, and not been documented which would not be unusual. Indeed [Witness 2]'s evidence was that she, too, had bleeped the doctors, but not documented the same. She confirmed in evidence that she would sometimes document this, but not always – it would not be uncommon for this escalation not to be documented on a particularly busy shift.*

21. *Accordingly, it is submitted there is no case to answer as to the facts of Charge 1c.*

*RE: Misconduct and Impairment*

22. *Alternatively, it is submitted there is no case to answer in respect of any of the charges, in that there is insufficient evidence for a Panel to find they amount to misconduct, and/or to find they could impair the Registrant's fitness to practise (both individually and cumulatively.*

23. *Even if any of the factual charges are found proven, it is submitted that any such breach of the NMC Code is not sufficiently serious*

*professional misconduct so as to be regarded as "deplorable" by fellow practitioners nor properly described as misconduct going to fitness to practise.*

24. *This is particularly so when one takes into consideration all the surrounding circumstances which are relevant to the charges, including:*

    a. *This was the Registrant's first ever shift on this ward, at this hospital and with this Trust, as an agency nurse;*

    b. *The Registrant received an inadequate induction/orientation to the ward. NMC witnesses have confirmed the entire orientation will likely only have lasted 10-15 minutes, and did not include the practice of who gives which 6am medications at what time and on what shift (which was a practice local to this ward). [Witness 1] agreed in evidence that it was unrealistic to expect a new nurse to understand and become conversant with the matters referred to on the orientation checklist form in that short amount of time;*

    c. *The Registrant was allocated Patient A who was a difficult patient in terms of clinical care – [they were] rather acutely unwell. [They had] suspected sepsis, ischaemic toes, Chron's, an ileostomy, wounds, abdominal pain and a whole host of medications prescribed to [them];*

    d. *Patient A required IV medication, but had no cannula so no method of receiving that medication. The Registrant could not cannulate herself. [They] also required oral medication, but was (for a time, at least) nil by mouth and nauseous/vomiting, so unable to received that medication either;*

e. *The ward was particularly busy, with fewer staff than usual, and a number of acutely unwell patients;*

f. *Very little to no support was offered or provided to the Registrant in these difficult circumstances;*

g. *The fact that some, but not all, 6am medications were required to be given by the day staff was not flagged with the Registrant at any time;*

h. *The handwritten drugs chart in use is extremely unclear and difficult to decipher. The same was accepted by [Witness 1] in her evidence. It is handwritten, there are additions made to it subsequently which are undated, a number of entries are not signed or initialled by the responsible clinician, and there is a numbered code used which is not obvious either. There is no evidence the Registrant was given any support in understanding this document and what was required of her from it;*

i. *This was a one-off clinical incident, relating to one patient, at one time, on one shift, at one hospital, on one occasion.*

25. *Accordingly and in these circumstances, it is submitted there is no case to answer in respect of any of the charges as to them amounting to misconduct or leading to a finding of current impairment.*

*<u>Conclusion</u>*

26. *In the light of all the above it is submitted the Registrant has no case to answer in respect of all charges against her."*

Ms Simpson submitted that in these circumstances, the charges should not be allowed to remain before the panel.

Mr March submitted that in relation to charge 1a, the NMC's case is that you were a registered nurse and irrespective of the difficulties and challenges of being an agency nurse on your first shift on a busy ward, one of your primary responsibilities was administering medication. The handover, the drug chart, the patient notes, and the contents of each, were key things you would need to refer to. Mr March submitted that it is not suggested that there is evidence that could be taken from the orientation that could be held against you. However, there was prima facie evidence of a handover being given and there was documentary evidence in the form of the drug chart and patient notes that you would have had access to. Mr March submitted that irrespective of the challenges as an agency nurse, it was an inevitable part of your job to look at a drug chart and take action if there was anything that had not yet been administered.

Mr March agreed with Ms Simpson's submission that the drug chart was not the most straightforward to follow and it is right that oral drugs were marked for administration at 6am which fell during the night shift. The panel heard evidence that there was an expectation and normal practice that may not have been communicated to you expressly, that most oral non-controlled drugs were administered on the day shift. However, Witness 3 explained that irrespective of any doubt about this, there was still an apparent failure. A registered nurse coming on to a shift was expected to take responsibility for their patients. One of these responsibilities is to check their drug charts and patient notes. Patient A was prescribed Phenytoin, and it was also clear from the drug charts because of the timing in which the Phenytoin was administered. The initials of Witness 1 showed that the drug was not administered until much later. Consequently, it should have been clear to you when you took over the shift, that the Phenytoin had not been administered. At the time you became responsible for Patient A, there was a drug that had been prescribed, there was a blank box which indicated that the drug had not been administered and there were no markings on the chart to suggest any clinical reason why the drug should not have been administered. Mr March submitted that any registered nurse looking at this drug chart, regardless of the contents of the handover, would have seen that Patient A had not yet been administered Phenytoin.

Mr March referred to one of Ms Simpson's submissions that arguably, the night shift nurse should have administered the prescribed drug intravenously (IV) and therefore it would have fallen during their shift. Ms Simpson also submitted that it was reasonable to assume that because the drug chart said "*IV*" and "*6am*", it could be taken to be a drug that had been administered already. Mr March submitted that this does not remove the responsibility or duty in this case as Witness 3 explained that simply leaving a box completely empty for a drug that had in fact been administered would be highly unusual.

Mr March referred to Ms Simpson's submission that Patient A was nil by mouth. The panel were shown an entry within Patient A's notes at 7am stating "*restart oral*". The panel were also shown another entry at 8:55am well into your shift which stated, "*no vomiting, asking for food, restart soft diet*". Mr March submitted that although Patient A may have been nil by mouth previously, there was an entry stating "*restart oral*". Therefore, you should have made enquiries or investigations about this and there is no evidence to suggest you did so.

Mr March submitted that in relation to Charges 1b and 1c it has always been the NMC's case that they are alternatives, and the panel cannot effectively find them both proved. The evidence even at this stage may point generally to you not being cannula trained and it is accepted that it cannot be your responsibility to administer a drug which would have required further cannulation. Mr March submitted that you have not yet given evidence that you are not cannula trained and this is why the panel should consider Charges 1b and 1c as alternatives. The panel has heard clear prima facie evidence from Witness 2 about the handover, explaining that cannulation was required and that she recalled nothing being said by you to the effect that you would have been unable to do this.

Mr March submitted that in respect of Charge 1c, and Ms Simpson's submission that your evidence has "*consistently been that [you] did refer this Patient to the medical/surgical team of doctors, but they did not follow-up. [You] states this in [your] relatively contemporaneous statement of 27 October 2019 [**97**] and in [your] first response to the NMC [**102**]",* the panel should consider this statement in the

documentation. He referred the panel to your factual description of what occurred during the incident:

> *"It was my first shift in the North Devon District hospital at King George 5th ward. The shift started at 7 am and I received a handover from the night staff. I was allocated 7 patients, one of whom was displaying signs and symptoms of sepsis. This particular patient had a history of epilepsy too. The night nurse did not handover to me that only 1/3 rd dose ( 200 mg) of his epilepsy medication (Sodium Valproate) was administered as 6 am, as opposed to 600 mg intravenously. As such, I assumed that the medication was administered and proceeded with the 7 am drug round."*

Mr March submitted that this is not consistent with the escalation alleged. It may well be that you "*bleeped*" for a doctor when you noticed something was wrong with Patient A. However, the allegation is that what needed to be escalated was that Patient A had not received their full prescribed dose and this needed to be done soon, not waiting till something went wrong visibly. The first urgent task that day was to re-cannulate and if this could not be done, then to escalate so that someone else could. Mr March submitted that your defence is that it was not handed over and as a result, you assumed the dose had been administered. Mr March submitted that it is this assumption that is illustrative of the problem of a registered nurse not carefully looking at the drug chart of a patient, but rather, making a dangerous assumption.

Mr March submitted that it is accepted that it was your first shift on a busy ward as an agency nurse and that it was a challenging environment and role. However, an inherent part of being a registered nurse includes the basic nursing practice of checking the drug chart of a patient you are responsible for and ensuring that drugs that do not appear to have been administered or have been administered only in part, are investigated, and administered as required.

Mr March acknowledged Ms Simpson's submission that you had received inadequate induction to the ward and witnesses had been inconsistent about the orientation. He submitted that although this is some mitigation, the evidence in respect of the

orientation has been less than satisfactory and it may be a learning point in how the Ward carries out its orientation. However, it does not go to your failure and alleged misconduct and Witness 2 was clear in her evidence about what she said to you during the handover.

Mr March referred to Ms Simpson's submission that Patient A was difficult and acutely unwell. He submitted that although this was challenging, this will be more relevant to consider at the sanction stage rather than the misconduct stage.

Mr March acknowledged Ms Simpson's submission that very little support was offered to you and accepted that the Ward was busy. However, there are clear issues when looking at Patient A's charts that a drug had not been fully administered and there is no evidence that you asked your colleagues for any support.

Mr March submitted that although the drug chart is not easy to understand, there is nothing confusing about the empty box which indicated that a drug had not been administered. He referred the panel to Witness 3's evidence in considering misconduct on a single occasion in which she stated that missing epileptic medications are more serious. Patient A was unwell and suffered a seizure as a result of not receiving the full dose of his medication. He submitted that this is capable of amounting to serious misconduct.

**Panel's decision**

The panel took account of the submissions made by Ms Simpson and Mr March and accepted the advice of the legal assessor. There was no dispute as to the legal test, as submitted by Ms Simpson.

The panel considered the application carefully in respect of each of the charges. The panel had regard to all the evidence adduced by the NMC both written and oral. The panel was mindful of the test in considering such applications, as set out in the judgment of Lord Lane LCJ in *R v Galbraith [1981] 1WLR 1039*.

The panel was mindful that it was not deciding whether any of the disputed charges was proved, only whether, applying the *Galbraith* test to the NMC evidence, it could find the charges proved. In regulatory proceedings, the panel should ask itself the question "*is there any evidence upon which a properly directed panel could find the alleged facts proved?".* If the answer is "*yes it could*", (not that it would), then the panel should proceed to hear the defence case.

**Charge 1a** – On 9 July 2019, failed to:

a. Administer and/or ensure administration of Phenytoin to Patient A.

**There is a case to answer for this charge.**

The panel determined that in light of the regular administration of Phenytoin being essential in Patient A's care in preventing seizures, there was a prima facie case that there was a duty on you to ensure that this medication was administered. The panel heard evidence from all 3 witnesses, that it was local practice for the morning oral medications to be administered by the day shift staff. The panel heard evidence from Witness 2 that she did not administer the 6am medication of Phenytoin because of this practice.

The panel was satisfied that having taken responsibility for Patient A, there was a prima facie case that it was your duty to check the drug chart and administer any drugs that had not yet been given. The panel determined that it could conclude that as you were an experienced nurse, you should have known when looking at this chart that the Phenytoin needed to be administered to Patient A.

The panel therefore determined that there was a case to answer in respect of this charge.

**Charge 1b** – On 9 July 2019, failed to:

b. Administer the remainder of the dose of sodium valproate to Patient A, as only 200mg of the prescribed dose of 600mg had been administered.

**There is no case to answer for this charge.**

The panel determined that in relation to the failure, it had to consider whether you were under a duty to administer the remainder of the dose of sodium valproate to Patient A. The panel noted that there is no evidence before it that you could cannulate patients. The panel had regard to Witness 1's oral evidence in which she stated: *"I do not remember if the agency staff knew how to cannulate. I asked her to prioritise the patient and make sure he was cannulated. If she couldn't, then the doctors can cannulate. We have doctors who can cannulate. I don't recall if the previous nurse (Witness 2) could cannulate".* The panel noted that it heard from Witness 2 that she did not have the skills to cannulate hence why she called on the doctors. It is accepted that at the time, Patient A had already received a third of the required dose of Sodium Valproate and already had a cannula in situ, which was noted to be tissued.

The panel determined that these were the actions you should have taken if you were competent to do so. The panel has seen your cannulation certificate which post-dates these events. There is also evidence before the panel that you did not have the competence to cannulate at the time of these events as you state in your reflective statement: *"Will go on a cannulation course so that, if such situation arises again, I will be able to cannulate patients myself and prevent delays in care."* In light of this, the panel determined that you could not have been under a duty to administer the remainder of the dose of sodium valproate to Patient A.

The panel therefore determined that there was no case to answer in respect of this charge.

**Charge 1c** – On 9 July 2019, failed to:

c. Escalate that Patient A had not received their full prescribed dose of Sodium Valproate.

**There is a case to answer for this charge.**

The panel noted the evidence from Witness 2 that she had only been able to administer 200mg of sodium valproate to Patient A and could not continue because of the tissued cannula. In her oral evidence, Witness 2 stated that during the handover to you she explained that as a night shift nurse she only administered IV medications and controlled drugs, and anything other than that after 6am would have to be administered by the day shift staff. The panel considered Witness 2's evidence that she did not record this because she had informed you of this during her handover to you and also that you needed to follow up with the doctor. Witness 2 referred the panel to Patient A's notes in which there is an entry that reads *"please ask doctors to review"* and another entry at 7am stating *"only had 200mg of the drug unable to tolerate as stinging. Was able to tolerate IV…please ask doctors to review."*

The panel considered the documentary evidence, including the drugs chart which clearly showed the entry of 200mg being administered, as opposed to the prescribed dose of 600mg. The panel determined that this gave rise to a prima facie case that it was your responsibility to escalate the need for the full prescription to be administered.

The panel therefore determined that there is a case to answer in respect of this charge.

**Impairment**

The panel considered whether there was a case to answer in respect of impairment. It determined that Charges 1a and 1c may amount to misconduct and consequent impairment. It determined that consideration of a patient's drug chart could be considered to be a basic nursing duty and particularly in the circumstances of Patient A who was a seriously ill patient. Therefore, there was a prima facie case that you may have been seriously in breach of your duty.

The panel noted your reflective statement in which under the section on what you would do differently, you stated you will *"examine drug charts thoroughly, as well as other vital patients' documentation…".* This may be highly relevant in relation to the panel's consideration of impairment. The panel has not heard any evidence to determine this position finally on the facts and has not yet heard any oral evidence in relation to insight.

At the present stage, the panel determined only that it is possible that a finding of impairment might be made.

**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 March on behalf of the NMC and by Ms Simpson on your behalf.

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

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

- Witness 1: Staff Nurse, at North Devon Healthcare Trust.
- Witness 2: Staff Nurse, at North Devon Healthcare Trust (at the time of the incidents).
- Witness 3: Band 7 Ward Sister North Devon Healthcare Trust.

The panel also heard evidence from you under affirmation.

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

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

**Charge 1a**

1) “On 9 July 2019, failed to:

a. “Administer and/or ensure administration of Phenytoin to Patient A.”

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence provided by Witness 2, your evidence, and the documentation provided by the NMC. It determined that having taken over responsibility from Patient A from Witness 2, the duty of care for Patient A was handed over to you. This duty included ensuring that you were aware of Patient A’s medication requirements. The panel determined that if there was a lack of clarity on what Patient A's medication requirements were, you were responsible for seeking clarity on this and ensuring that you established precisely what these medication requirements were.

The panel acknowledged your evidence that the ward was busy and that the recordings on the drug chart could have been clearer. It accepted this, along with the potential difficulty there may have been in the information that was handed over to you. Nevertheless, the panel determined that as an experienced nurse, it was your duty to ensure that you had a full understanding of Patient A’s medication requirements and the administration of such.

In your oral evidence, you accepted that you did not administer the Phenytoin. The panel finds that this was an important admission. It was apparent from the drug chart that the Phenytoin had not been given to Patient A. This accords with the NMC witnesses’ evidence that the Phenytoin was not administered. Accordingly, the panel concluded that you neither administered nor ensured the administration of Phenytoin to Patient A.

The panel therefore finds this charge proved.

**Charge 1c**

1) *"On 9 July 2019, failed to:*

   c. *Escalate that Patient A had not received their full prescribed dose of Sodium Valproate."*

**This charge is found proved.**

In reaching this decision, the panel took into account your oral evidence, the patient notes, the drug chart in which it was clearly noted that only 200mg of the full 600mg dose had been administered, and the evidence provided by Witness 2.

The panel had regard to Witness 2's evidence that Patient A had been partially administered the prescribed sodium valproate and that there had been difficulties with cannulisation. The panel also had regard to your oral evidence that you recall Witness 2 saying something to you in relation to this. On that basis, the panel determined that you should have understood that you were under a duty to ensure that the remainder of the dose was to be administered. It further determined that for the reasons set out in Charge 1a, having taken responsibility for Patient A, it was your duty to ensure that the correct medications were given. If you were unclear on anything in relation to this, it was your responsibility to seek clarity.

The panel determined that in relation to whether you breached the duty, the full dose of the drug was meant to be given and you were responsible for escalating this. The panel considered submissions from Mr March that your reflective statement contradicted your oral evidence. The panel accepted this submission. In your oral evidence, you stated that you escalated *prior* to having concerns about the deterioration of Patient A's health, as was required of you. This would suggest that you were aware that the full dose of sodium valproate had not been given. However, in your reflective statement you stated that you were not aware that the full dose had not been given, that this had not been handed down by Witness 2, and therefore you assumed the full dose had been given.

The panel accepted Mr March's submission that had you thought that the full dose had been administered, there would be no reason for you to escalate in the circumstances.

The panel was satisfied that the account given by Witness 2 was correct and that you failed to escalate that Patient A had not received the full prescribed dose of Sodium Valproate.

The panel therefore finds this charge proved.

**Decisions and reasons on proceeding in the absence of Ms Tzvetkova**

The hearing resumed on Thursday 17 October 2024, where you did not attend the hearing but were represented by Ms Simpson. Ms Simpson told the panel that [PRIVATE] so you are unable to join the hearing. She said that you have instructed her that you are happy for the hearing to proceed in your absence.

Ms Churaman submitted that the hearing should proceed in your absence in order to reach a conclusion expeditiously.

The panel took into account that you have instructed Ms Simpson to represent you in these proceedings and that you previously gave evidence. In accordance with both parties' submissions, the panel decided to proceed with the hearing in your absence.

**Fitness to practise**

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that

there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

**Submissions on misconduct**

Ms Churaman invited the panel to take the view that the facts found proved amount to misconduct. She referred the panel to The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) and identified the specific, relevant standards where your actions amounted to misconduct. She submitted that the misconduct in this case is serious and falls short of the standards expected of a registered nurse.

Ms Simpson accepted that your failure to administer medication to Patient A and not escalating this did constitute a breach of the Code. She submitted that your actions do not amount to behaviour falling far short of what is expected of a registered nurse and is not deplorable.

Ms Simpson drew the panel's attention to the circumstances around your actions. She told the panel that the charges relate to a single incident involving one patient, you were on your first bank shift as an agency nurse on that ward, you had received an inadequate orientation and were offered very little support.

Ms Simpson invited the panel to find that your actions did not amount to serious misconduct.

**Submissions on impairment**

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

Ms Churaman acknowledged that you have shown some insight in that you have completed some training to address the regulatory concerns and have reflected on your actions. She submitted, however, that this is inadequate and that your lack of candour demonstrates that you have limited insight.

Ms Churaman submitted that your failures relate to basic nursing care and that you have undermined the undermined the reputation of the nursing profession. She submitted that a finding of impairment is necessary to uphold the standards of the nursing profession.

Ms Churaman invited the panel to make a finding of impairment in relation to your fitness to practise.

Ms Simpson submitted that your fitness to practise is not impaired. She reminded the panel that whilst you accept that your actions put Patient A at risk of harm, there is no evidence to support that Patient A had a seizure as a result of you failing to administer their medication.

Ms Simpson submitted that the conduct in this case is easily remediable and that it has been remedied and not been repeated since. She submitted that you have strengthened your practice in that you are now trained to insert cannulas and have also completed training in medication administration. She also referred the panel to your reflective piece where you have said what went wrong and what you would do differently in the future.

The panel accepted the advice of the legal assessor which included reference to *CHRE v NMC and Grant*.

**Decision and reasons on misconduct**

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

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

*To achieve this, you must:*

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

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

***8 Work cooperatively***

*To achieve this, you must:*

*8.2 maintain effective communication with colleagues*

***13 Recognise and work within the limits of your competence***

*To achieve this, you must, as appropriate:*

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel took into consideration that you had been handed the care of Patient A, who was very vulnerable and a priority patient, and that it was imperative that you ensured that all of their medical needs were met.

The panel took into account the context in which the incident took place. However, it found that, although you were inexperienced in the acute medical ward environment, you were an experienced nurse, having previously worked in acute settings. The panel found that you failed to demonstrate basic nursing skills by not giving proper consideration to Patient A's drug chart and escalating to senior doctors when you were unable to administer the medication. The panel also took into account that in the course of your evidence you stated that you were unaware that you were required to administer the 06:00 drug round to patients however noted that there is evidence that shows that other patients were administered their medication by you in the 06:00 drug round during that shift.

Having taken all of this into account, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

**Decision and reasons on impairment**

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

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and

open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. At 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.'*

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that s/he:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *…'*

The panel found that Patient A was put at risk of harm as a result of your misconduct. Your misconduct breached the fundamental tenets of the nursing profession, to prioritise and care for patients and work collaboratively with colleagues. The panel therefore determined that your conduct brought the nursing reputation into disrepute.

The panel considered your registrant's response bundle, which included references from former colleagues, a reflective piece and training certificates. The panel was of the view that the misconduct identified in this case is capable of being addressed. However, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account your reflective piece. The panel acknowledged that whilst you have reflected on what you would do differently in the future, you do not appear to accept responsibility for ensuring that Patient A received their medication. The panel gave particular regard to the following:

> *'As a starting point the amount of people which were assigned to the nurse (nurse: patient ratio) was not safe to be managed especially as there was critically ill patient.*
> *The handover from the night nurse was not properly and was incomplete.*
> *The medical team didn't act speedily and didn't intervene after they were told.'*

The panel found that whilst you have shown insight, it has been very limited as you have failed to show remorse for your actions, have not taken responsibility for your role in the incident and the consequences namely that a vulnerable patient did not receive their prescribed medication. The panel also found that as a result of your limited insight there is a risk of repetition.

The panel noted your previous experience in a neurological hospital ward and had regard to your testimonials from former colleagues which said:

> *'She was always very proactive, informing the relevant teams for any complications…*

*She is extremely assertive, capable enough to take urgent decisions when a patient worsens suddenly.'*

The panel considered that, as an experienced nurse described as one who was capable of making decisions in urgent situations, you should have escalated any issues to a more senior member of the team if you had concerns about patient safety. The panel further considered that you should have had an awareness of the importance of checking the drug chart of a patient in your care and of clarifying medication needs if in doubt. The panel was of the view that if your misconduct was to be repeated to another patient then your failure could have a more serious outcome. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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 12 months. The effect of this order is that 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 careful regard to the Sanctions Guidance (SG) published by the NMC.

**Submissions on sanction**

Ms Churaman submitted that, given the panel's findings of serious misconduct and impairment as well as the charges found proved, it is the NMC's position that the appropriate sanction in this case is a conditions of practice order.

Ms Churaman submitted that in terms of the aggravating factors, the panel should consider that you have shown limited insight into your misconduct, you put Patient A at risk of harm and that you have shown a lack of candour throughout these proceedings.

Ms Churaman submitted that in terms of mitigating factors, the only real mitigation is that you have undertaken training to address the concerns raised.

Ms Churaman submitted that the misconduct in this can be remediated and that a conditions of practice order is sufficient in protecting the public and meeting the public interest.

Ms Simpson reminded the panel of its responsibility in finding the balance between fairness to you and the NMC's overarching objective in protecting the public. She also reminded it that you should not be penalised for challenging these charges.

Ms Simpson submitted that your conduct should be considered within its proper context, particularly, that the conduct found proven involves one patient on one shift. However, she stated that you do not seek to downplay the seriousness of the concerns in this case and that you accept you had a responsibility in ensuring that Patient A received their medication and that you are remorseful for your actions.

Ms Simpson submitted that as the misconduct in this case relates to clinical concerns and you show a developing insight and you have a desire to return to nursing, a

conditions of practice order is the most suitable order. She provided the panel with suggestions of conditions to impose, including indirect supervision and regular meetings with your manager.

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 in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Your limited insight into the impact of your misconduct.
- Your conduct put Patient A at risk of harm.

The panel also took into account the following mitigating features:

- You have undertaken relevant training to address some of the concerns raised.

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

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

*was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

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

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

The panel noted that the misconduct in this case was an isolated incident that does not appear to have been repeated and that you have today through your representative have expressed remorse for the part you played and the consequences to Patient A. The panel also noted that you have demonstrated a willingness to strengthen your practise as you have undertaken relevant training courses to mitigate some of the risks identified. The panel 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.

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case.

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 ensure that you are supervised by another registered nurse when undertaking a medication administration round. You must be supervised until you have been deemed competent in completing the medication administration round by a Band 6 nurse or above.

2. You must have monthly meetings with your line manager, supervisor or mentor to discuss:
   a) Communicating effectively with colleagues.
   b) Managing and escalating risk.

3. A report must be sent to the NMC, prior to any review hearing, from your line manager, supervisor or mentor detailing:
   a) Your communication with colleagues.
   b) Risk management in your practice.

4. 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.

5. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any agency you apply to or are registered with for work.
   c) Any employers you apply to for work (at the time of application).
   d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

6. 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.

7. 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 12 months. This is to allow you sufficient time to find employment and engage with the conditions of practice order.

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 continuing professional development.
- A report from your employer on your competency in performing medication administration rounds, communicating with colleagues and managing and escalating risk.

This decision will be confirmed to you in writing.

**Interim order**

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

**Submissions on interim order**

The panel took account of the submissions made by Ms Churaman. She invited the panel to impose an interim order for a period of 18 months

The panel also took into account the submissions of Ms Simpson. She reminded the panel that an interim order must be necessary rather than desirable.

The panel accepted the advice of the legal assessor.

**Decision and reasons on interim order**

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

The panel concluded that 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.

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.