Nursing Council of Hong Kong

Disciplinary Inquiry

Nurse Registration Ordinance (Cap. 164)

No.: NC 482/7/B and NC 3261/7/B (consolidated)

Dates of Hearing: 30th August 2022, 4th February 2023, 9th February 2023 and 10th August 2023

Defendant: Ms. X ([redacted])

DECISION

Case No.: NC 482/7/B

1. By a Notice of Inquiry dated 12th October 2021, the present inquiry is held against Ms. X ("the Defendant") as a registered nurse in the matter as follows:

> *"[t]hat…, at the Chinese YMCA of Hong Kong -Home of Love-Yung Shing Hostel,*
>
> *(i) during May 2017 to June 2017, failed to maintain the best possible standard of care within the reality of the working conditions by failing to administer the medications to a patient namely Mr. A ('the Patient A') in appropriate time interval according to medical prescription (i.e. giving instruction in administering the medications at 5:00 p.m. and 9:00 p.m. daily (with only 4 hours in between), thus jeopardizing the safety and interests of the Patient A; and/or*

(ii) during May 2017 and June 2017, failed to ensure that the standard of practice is congruent with the standard of the profession by not administering the correct quantity of beverage thickener to the beverage for a patient namely Mr. B ('the Patient B'), according to medical prescription given by the speech therapist (i.e. giving instructions in adding 7.5 ml instead of 17.5 ml of beverage thickener to 100 ml of water), thus jeopardizing the safety and interests of the Patient B; and/or

(iii) on 7 June 2017, failed to provide care in a manner that protects the individual's privacy and dignity by arranging male staff in joining the bathing training for a female patient,

and that in relation to the facts alleged, either singularly or cumulatively, ...have been guilty of unprofessional conduct."

Case No.: NC 3261/7/B

2. By a Notice of Inquiry dated 12th October 2021, this inquiry is held against the Defendant as an enrolled nurse in the matter as follows:

"[t]hat..., at the Chinese YMCA of Hong Kong -Home of Love-Yung Shing Hostel,

(i) during May 2017 to June 2017, failed to maintain the best possible standard of care within the reality of the working conditions by failing to administer the medications to a patient namely the Patient A in appropriate time interval according to

medical prescription (i.e. giving instruction in administering the medications at 5:00 p.m. and 9:00 p.m. daily (with only 4 hours in between), thus jeopardizing the safety and interests of the Patient A; and/or

(ii) during May 2017 and June 2017, failed to ensure that the standard of practice is congruent with the standard of the profession by not administering the correct quantity of beverage thickener to the beverage for a patient namely the Patient B, according to medical prescription given by the speech therapist (i.e. giving instructions in adding 7.5 ml instead of 17.5 ml of beverage thickener to 100 ml of water), thus jeopardizing the safety and interests of the Patient B; and/or

(iii) on 7 June 2017, failed to provide care in a manner that protects the individual's privacy and dignity by arranging male staff in joining the bed bathing training for a female patient,

and that in relation to the facts alleged, either singularly or cumulatively, ...have been guilty of unprofessional conduct."

Consolidation of cases NC 482/7/B and NC 3261/7/B

3. [redacted] of Messrs. Raymond Siu & Lawyers ("[redacted]") represents the Defendant in both the above cases, namely, NC 482/7/B and NC 3261/7/B. Both the cases are identical save and except (i) the capacities of the Defendant being a registered nurse in NC 482/7/B and an enrolled nurse

NC 3261/7/B; (ii) the procedure of present inquiry on these two cases are governed by different but identical sub-legislations being Cap. 164A and Cap. 164B respectively, these cases are arising from the same incidents and (iii) the allegations and factual background of both cases are the same. Upon [redacted]'s application for consolidation of these two cases and the legal officer of the Secretary of Nursing Council of Hong Kong ("[redacted]") raising no objection, this Council orders that the two cases to be heard together.

Admitted Facts dated 30th August 2022

4. The Defendant was an enrolled nurse and a registered nurse on 10th May 1995 and 15th December 2016 respectively.

5. The Enrolled Nurses (Enrolment and Disciplinary Procedure) Regulations (Cap 164 B) is applicable to case NC 3261/7/B.

6. The Nurses (Registration and Disciplinary Procedure) Regulations (Cap 164 A) is applicable to case NC 482/7/B.

7. It is not disputed that the Defendant was the only qualified nurse at the Chinese YMCA of Hong Kong-Home of Love-Yung Shing Hostel (the "Hostel") from 4th May 2017 to 1st July 2017.

8. The admissibility of the documents in the Secretary's Bundle is not challenged.

9. It is admitted that the 8 medications in the form of ointments in charge 1 were prescribed by the Doctor's prescription to the Patient A.

The 3 Allegations Against the Defendant

10. There are 3 allegations against the Defendant in the present inquiries as stated in the Notices of Inquiry as enrolled nurse and registered nurse:

Allegation 1 - Failure to administer the 8 medications to the Patient A, in appropriate time interval in accordance with the medical prescription (the "Ointment Incident").

Allegation 2 - Failure to ensure that the correct quantity of beverage thickener was added to the beverage for the Patient B (the "Beverage Thickener incident").

Allegation 3 - failure to provide care in a manner that protects the individual's privacy and dignity by arranging male staff to participate in the bed bathing training of a female patient on 7th June 2017 (the "Bed Bath Incident").

The Law

11. At all material times, the Defendant was (and still is) a registered nurse and an enrolled nurse governed by the Nurses Registration Ordinance (Cap. 164) ("NRO").

12. Section 17(1) of the NRO provides, if, after due inquiry, the Council is satisfied that any registered/enrolled nurse has been, in Hong Kong, guilty of unprofessional conduct, the Council may inter alia order that the name of the

registered/enrolled nurse be reprimanded or that his/her name be removed from the register of nurses (the "register") or roll of enrolled nurses (the "roll") (or any part thereof), either permanently or for a specific period of time.

13. Section 17(3) of the NRO, "unprofessional conduct" means an act or omission by a registered/enrolled nurse which could be reasonably regarded as disgraceful or dishonourable by registered/enrolled nurses of good repute and competency.

14. The Code of Ethics and Professional Conduct for Nurses in Hong Kong (January 2015 version) provides guidance on fundamental ethical commitments and obligations of the nursing profession and serves as the basis for decisions regarding the standards of ethical nursing practice and professional conduct.

The Relevant Legal Principle

15. It is the Legal Officer's duty to prove her case and the standard of proof shall be on a balance of probability.

16. Compelling evidence is needed in proving serious allegations.

17. In evaluating the weight of the Defendant's evidence, it should be born in mind that, at the time of present complaint, the Defendant has been working as a nurse for over 22 years (i.e. from 1995 to 2017) and free from any complaint relating to her professional conduct. The Defendant's evidence should therefore be

evaluated in the light of her having less propensity in committing the alleged conducts in question.

The Secretary's Case

18. The Legal Officer, [redacted], called 5 live witnesses to testify and relied on the documents in the Secretary's bundle to prove her case.

19. The said 5 witnesses called by [redacted] are:

(a) Mr. [redacted] (transliterated)) ("PW1");
(b) Mr. [redacted] (transliterated)) ("PW 2");
(c) Ms. [redacted] (transliterated)) ("PW 3");
(d) Ms. [redacted] (transliterated)) ("PW 4"); and
(e) Ms. [redacted] (transliterated)) ("PW 5").

The Defence Case

20. [redacted] called 2 live witnesses to testify, namely,

(a) Dr. [redacted] ([redacted]) ("[redacted]"); and
(b) The Defendant.

Allegation 1 - the Ointment Incident

21. It is an agreed fact that the doctors' prescription was that the 8 medications (ointments) in question were to be administered twice daily.

22. In considering this allegation, 5 questions should be asked, namely:

(a) Who gave the instructions?
(b) When were the instructions given?
(c) What were the instructions?
(d) Were the instructions consistent with the doctor's prescription?
(e) If answer to (d) above is in negative, would it jeopardizes the safety and interest of the patient?

Who gave the instructions?

23. It is an admitted fact that a "Workflow of Nursing Department (護理部工作流程)" (the "Workflow") was prepared by the Defendant in May 2017 and it was posted on the billboard for the purpose of providing guidelines on personal care to the staff members of Nursing Department (including Personal Care Worker (個人照顧員/護理員)and Health Worker(保健員)). The Defendant agreed that the relevant staff members of the Nursing Department (i.e. Health Worker (保健員), Personal Care Worker (個人照顧員/護理員) and Ward Attendant (院舍服務員)) should and would follow the guidelines.

24. PW3 was the Health Worker (保健員) at the material time. PW3 testified that: (i) The Defendant told her that the Workflow was made by the Defendant; (ii) it was the Defendant's instruction to deliver the Workflow to the file trays of all staff members of Nursing Department and Ward Attendant (院舍服務員); and (iii) The Defendant also asked the staff members of Nursing Department to follow her instructions.

25. [redacted] submits that the Defendant had no power to give instructions to the staff members of Nursing Department.

26. PW1's evidence is that the Defendant was the person in charge of the Nursing Department of the Hostel and was responsible for giving instructions to the fellow staff members of Nursing Department. PW1 was the Executive Secretary of the Chinese YMCA of Hong Kong at the material time.

27. It is also an admitted fact that the Defendant was the only qualified nurse working in the Hostel at the material time. As the only qualified nurse of the Hostel, it is difficult to imagine that she has no power to give instructions to other staff members of Nursing Department.

28. The Council is of the view that it matters or not whether the Defendant had the power to give instructions to the staff members of Nursing Department and whether it was within or outside of her employment contract, she did give such instructions with the knowledge that she was the only qualified nurse at the time when she issued the Workflow and had at the very least assumed the duties and responsibilities of a qualified nurse. In fact, as the only qualified nurse, the Defendant has the responsibility to provide safe and competent practice. She should practice and maintain the best possible standard of care within the reality of the working conditions.

29. The Council finds that the Defendant had given those instructions.

When were the instructions given?

30. As stated in paragraph 23 above, it is the Defendant's own evidence and indeed an admitted fact, that she made the Workflow in May 2017 and the same was posted on the billboard.

31. The Council finds that, as the instructions related to the administering ointments are stated in the Workflow, such instructions took effect when it was posted (i.e. May 2017).

What were the instructions?

32. It is not disputed that the Workflow was applicable to all patients including Patient A.

33. It is the Defendant's evidence that she had separated the medical and non-medical ointment by putting the medical ones in boxes such that the health workers would know to follow medical prescription when applying the medical ointments.

34. The Defendant was unable to disagree that the Workflow did not make any differentiation between medical and non-medical ointments on the plain reading of the workflow.

35. The Defence case is that afternoon 17:00 + after dinner 21:00 stated in the Workflow was for non-medical ointments only, and the medical ointments should be applied in accordance with the doctor's prescription.

36. The Defendant agreed that by reading the workflow it is not apparent that the instructions related only to non-medical ointments. In any event the plain reading of the part in the workflow relating to administering ointment is not consistent with the Defendant's version that it refers to non-medical ointments only.

37. Furthermore, the workflow simply does not suggest or hint that it applies to non-medical ointments only. The plain reading of the workflow can only mean that ointments were to be applied at 5pm and 9pm and made no differentiation between medical and non-medical ointments.

38. The Council is of the view that the subject instruction (i.e. afternoon 17:00 + after dinner 21:00) in the Workflow relates to the administering of both medical and non-medical ointments.

Were the instructions consistent with the doctor's prescription?

39. It is agreed by the parties that the Ointment Incident involved 8 medications (ointments) which, as prescribed by doctor, should be administered twice daily.

40. [redacted] relies on a common-sense approach to support her case that the relevant parts of workflow is not consistent with the doctor's prescription. Twice daily cannot mean 4 hours apart.

41. [redacted]'s evidence is that, unless the doctor instructs/directs otherwise, there is no strict rule for the time of administering ointment. An appropriate time interval is good enough.

42. Dr. [redacted] further testified that:

(i) if there is a need for a certain time interval, it should be stated clearly;

(ii) normally, if doctor's prescription is "twice daily", the time interval should be more than 4 hours; and

(iii) if the prescription says twice daily, the ideal time interval should be 8 to 12 hours.

43. The Defendant has working experience in a hospital, she agreed with Dr. [redacted]'s opinion that the ideal time interval for "twice daily" is 8 to 12 hours.

44. It is the Defence case that the time interval of 4 hours is not inconsistent with the doctor's prescription as there is no strict rule to the time interval and the doctor's prescription did not specify the time for administering the 8 ointments in question.

45. The time interval of 4 hours may not contradict the wording of the doctor's prescription; it is a matter of fact that the time interval of 4 hours would in effect reduce the exposure time of the ointments on the patient's body. Application of an ointment at a 4-hour interval would expose the patient to a 20-hour gap of

a medicated ointment. It is not conceivable that a doctor would prescribe a twice daily dosage to be applied 4 hours apart.

46. The Council is of the view that the Defendant's instruction is not consistent with the doctor's prescription.

Whether it would jeopardize the safety and interest of the relevant patient?

47. Dr. [redacted]'s evidence is that the medications (3 out of 8 ointments in question) would be less effective if the time interval between the last dosage and the next dosage is too far apart.

48. It is, however, a fact that the Patient A was left with a longer exposure of no medicated ointment when the application time was 4 hours apart.

49. The effectiveness of the ointment (at least 3 out of 8 ointments in question) has thus lessen and the Defendant's act did in effect jeopardize the safety and interests of the Patient A.

50. It matters not whether any complaint has been launched from the Patient A or his family members. A qualified nurse should act to the best interest of those under her care at all times.

51. The Council is of the view that the Defendant's act did in fact jeopardize the safety and interests of the Patient A.

Allegation 2 - the Beverage Thickener Incident

52. 4 questions should be asked in relation to allegation 2, namely:

(a) Who made the instructions/directions?
(b) What were the instructions/directions?
(c) Were the instructions/directions consistent with that of the speech therapist?
(d) If answer to (c) above is in the negative, whether it would jeopardize the safety and interest of the relevant patient?

Who gave the instructions?

53. PW2, the Internal Audit Manager of YMCA at the material time, testified that he saw two workflows, namely the Workflow and an illustrated beverage thickener workflow (the "Beverage Thickener Workflow") posted inside the Nursing Room (also referred to as office of Nursing Department) while he was conducting the investigation on 29 June 2017.

54. PW3, who was a Health Worker (保健員) of Home of Love at the material time, testified that the Defendant told her that the Beverage Thickener Workflow was prepared by her and the Defendant's instructed PW3 to deliver the Beverage Thickener Workflow to the file trays of the Ward Attendants and staff members of the Nursing Department.

55. The Defendant admitted that she prepared the Beverage Thickener Workflow and claimed that it was her draft note and the same had not been disclosed to the staff members of the Nursing Department. She further said that the

Beverage Thickener Workflow was stored in the office computer inside the office of the Nursing Department before her time.

56. The Defendant agreed that the thickness of the thickener on the note was her usual formula. It is not clear why the Defendant needed such "note" in the computer on a matter she was well acquainted with.

57. PW2 said he saw the Beverage Thickener Workflow posted in the Nursing Room and PW3 said the Defendant told her to deliver the said workflow chart to the staff members' trays.

58. The Defendant's evidence is that she cannot remember where she got the information from and agreed that she was very busy at the time and would not have make a note without intending for it to be left as instructions for other staffs.

59. The Defendant was the only qualified nurse at the home and it is hard to envisage anyone else giving such instructions.

60. The Council is unable to find a reason for both PW 2 and 3 to have lied and is of the view that the Defendant did give the instructions by preparing and issuing the Beverage Thickener Workflow.

What were the instructions?

61. Paragraph 4 of the Workflow relates to the use of beverage thickener and make reference to the "step-by-step illustration" when using the beverage thickener.

62. The Defendant explained that the "step-by-step illustration" referred to the instruction of the speech therapist rather than the Beverage Thickener Workflow. However, instructions of the speech therapist are only some drawings which are not "step-by-step illustration" for using the beverage thickener.

63. On the other hand, the description in the Workflow is more a "step-by-step illustration" as there were two images on it to illustrate the using of the beverage thickener. The Defendant said she had taken the photographs of those images.

64. The Defendant testified that she has no idea where the figures on the beverage thickener came from. She also testified that she usually applied 1-2 table spoons (5 ml) beverage thickener per 100ml. This is close to the quantity stated in the Beverage Thickener Workflow (i.e. 15 teaspoons per 1000 ml of water).

65. The Defendant also said she had called and confirmed with the Speech Therapist of the dosage because the faxed copy she received was blurred. There is no record of what the Therapist actually said or confirmed.

66. The Defendant agreed that she wrote the workflow but insisted that she did not mean for it to be instructions. The Council accepts that the workflow was posted in the staff room where the Defendant would have been one to have seen

it. The Council has therefore come to the conclusion that the Defendant did give the instructions of the quantity of beverage thickener to the staff members of nursing department through the Beverage Thickener Workflow.

Were the instructions consistent with the speech therapist?

67. It is not disputed that the Beverage Thickener Workflow stated 15 teaspoons per 1,000 ml of water, whereas the speech therapist had instructed that 3.5 teaspoons per 100 ml of water (equivalent to 35 teaspoons per 1,000 ml of water) should be the proper thickness for the Patient B.

68. The Council is of the view that the Beverage Thickener Workflow is not consistent with the Speech Therapist's instruction.

Whether it would jeopardize the safety and interest of the relevant patient?

69. It is a matter of fact that beverage thickener is used to minimize the risk of the patient choking. The Defendant was well aware of the importance of the thickener and the risk of choking on a patient should insufficient thickener is used.

70. The Council has therefore come to the conclusion that the Beverage Thicker Workflow would jeopardize the safety and interest of the patient.

Allegation 3 - the Bed Bath Incident

71. It is [redacted]'s case that the Defendant failed to provide bed bath in a manner which protects the female patient's privacy and dignity.

72. The following events during the bed bath are not disputed:

(a) The Defendant conducted a bed bath training on a female patient on 7th June 2017 in presence of 7 to 9 staff members including two male staff members, namely [redacted] ([redacted] (transliterated)) and [redacted] ([redacted] (transliterated)).

(b) While conducting the bed bath training, the Defendant and the male staff [redacted] ([redacted] (transliterated)) stood opposite to each other with the patient on a bed in between.

(c) There was a need to take off the clothes and pants during the bed bath training, albeit not necessarily at the same time.

(d) Male staff [redacted] ([redacted] (transliterated)) was able to see the female patient throughout the whole bath.

(e) The subject bed bath training was not a matter of emergency.

73. The Defendant testified that on the day of the Bed Bath Incident, the patient had just returned from the hospital and had torn off her diaper and her body was soiled with excrement and urine. There was a need to conduct the training in case the same situation was to arise at night when only one female staff and one male staff were on overnight shift duty. The Defendant also testified that the person in charge of Home of Love Ms. [redacted] ([redacted] (transliterated)), knew that there was a need to change the diaper, bath and

change the clothes of the patient. The Defendant was given to understand that permission was obtained and the family gave their authorization for the patient to be bathed by a male staff. In the present inquiry, Ms. [redacted] ([redacted] (transliterated)) was not a witness.

74. PW5 testified that in relation to bathing of a female patient, the Hostel has always adhered strictly to the guidelines under Service Quality Standards of the Hostel. It is the Hostel's standing arrangement that all female patients who are immobilized or in need of assistance, shall be showered/bath by a female staff and under no circumstances a male staff shall perform such duty or render assistance in doing so. Even if there are only one male and one female staff on overnight duty or in case of emergency, the male staff can only render assistance in grabbing hold of the female patient or passing stuff to the female staff when the female patient's body is not exposed. The family members of the patient clearly understood this arrangement and PW5 being the social worker responsible for the patient had never discussed any exceptional circumstances with the subject patient's family member and had not gotten the said authorization.

75. Though there is no evidence that the Defendant knew of the standing arrangement claimed by PW5, it is good practice, to say the least, that a nurse should respect the privacy and preserve the dignity of a patient best that the nurse can in the circumstances.

76. By comparing the evidence of the Defendant and PW5, it is obvious that their understandings of the "standing arrangement" for providing personal care to a female patient by a male staff was different.

77. It is PW4's evidence, who was a health worker of Home of Love at the material time, that there is no written or conventional guideline on conducting bed bath or rub clean on a female patient by a male staff. However, it is not clear whether such personal care service was permissible.

78. The real question to be asked is whether the patient's privacy and dignity were protected in the subject bed bath training regardless of any standing instructions. The Council repeats that a nurse should always act to the best interest of the person under his/her care, privacy and dignity protection is within the perimeter of best interest.

Whether the patient's privacy and dignity were protected in the subject bed bath training?

79. "Privacy" and "dignity" is not defined in the Code of Ethics and Professional Conduct for Nurses in Hong Kong (January 2015 version) and Service Quality Standards of the Hostel. It is unrealistic and impossible to list each and every scenario where nurses would find themselves in.

80. "Privacy" and "dignity" do not need a set of scenarios or definitions. In considering whether the patient's "privacy" and "dignity" are protected, this

Council would and should only look to the good sense of the nurse AND the circumstances of a particular set of facts.

81. Lying a female naked in front of a male, albeit for the purpose of a bath, for the purpose of training where there was no emergency can under no circumstances be sufficient protection of the female patient's privacy and dignity.

82. The issue of whether consent had been obtained before the Bed Bath Incident does not lend weight to the issue of whether the patient's privacy and dignity were protected. The mere fact that consent had been obtained does not alleviate the nurses' duty to protect the patient's privacy and dignity. If there were an emergency, for example, where life is on the line, different consideration would apply.

83. The Defendant testified that the subject bed bath training was aim at serving the subject female patient. However, this explanation does not change the fact that there was no emergency at all.

84. As it was inevitable that the subject patient's clothes and/or pants would be taken off during the bed bath training, the two male staffs were able to see the naked body of the female patient. The female patient's privacy and dignity were not protected.

85. The Council is of the view that the privacy and dignity were not protected in the Bed Bathing Incident.

Determination

86. The fact that no complaint was made by the relevant patients and/or their respective family members is irrelevant to the issue of whether the Defendant had misconducted herself as alleged.

87. It cannot be emphasized enough that one of the Council's primary functions is to ensure that nurses discharge their professional obligations properly, and protect the public interest when they should find themselves in need of nursing care. Patients are in their utmost vulnerability when placed under the care of the medical professionals, nurses are expected to be at the top of their game at all times when they are on duty.

88. The Council accepts that unprofessional conduct should not be judged on the fact that there were room for improvement or a better alternative was available. Unprofessional conduct is as defined in s.17(3) Cap 164, *"being an act or omission ....which could be reasonably regarded as disgraceful or dishonourable by registered/ enrolled nurses of good repute and competency."* This is the bases of the constitution of this Council wherein all members are of the nursing community.

89. The requirement for nurses to administer medications on patient in accordance with doctor's prescription is to ensure that the patient get the correct dosage which the doctor sees fit to be best for the patient. Deviation from doctor's prescription would jeopardize the safety and interest of the patient.

90. While appreciating the difficulties nurses may find themselves in situation when they are short staffed and that circumstances may seem impracticable or sometimes seemingly silly to insist on following the rules to the straight and narrow, the primary duty of a nurse is and always be to the patient.

91. Administration of medications is one of the primary duties of the nurse, prescriptions should be adhered by the professional, be that a medical doctor or any medical professional, who made the prescription had first-hand information of the patient. It is always encouraged that should a nurse finds herself questioning the prescription, she should make enquiries. It is, however never for the nurse to change the prescription on her/his own.

92. In the present case, as the doctor's prescription and the speech therapist's instruction were not reflected correctly in the Ointment Incident and the Beverage Thickener Incident respectively. The patient was exposed to a much longer time without the medicated ointments and the less than enough beverage thickener had increased the patient's risk of choking. Such deviation would jeopardize the safety and interest of the relevant patient.

93. In providing personal care to a patient, nurses are obliged to save guard the patient's privacy and dignity best that they can. Any unnecessary exposure of the patient's naked body in the presence of another is to be avoided let alone someone of a different gender.

94. As regards the Bed Bath Incident, it is obvious that the bed bath training itself was not an emergency and the Defendant should have chosen an alternative way to preserve the patient's privacy and dignity.

95. The Council has thus concluded that all 3 charges against the Defendant has been proved.

96. The 3 charges, either singularly or cumulatively, constitutes unprofessional conduct.

Mitigation

97. [redacted] submitted documents in respect of the Defendant's employment since December 2018 and a praising letter from a relative of a patient under the Defendant's care.

98. The Council accepts that this matter has taken longer than usual, but that has been a fact in the face of Covid-19 for everyone. The Council also accepts that the Defendant has since late 2018 been engaged in the nursing profession.

99. This is the Defendant's first disciplinary hearing in her nearly 22 years of practice in 2017.

Orders

100. The Council considers the unprofessional conducts to be serious though of different degrees.

101. Ointments were actually applied in the Ointment incident and though the patient was exposed to a longer period of time with no medication, the patient was left with some medication.

102. It is ordered that the Defendant be removed from the register and the roll for a period of 1 month.

103. The Beverage Thickener incidence is more serious as there was a real risk of the patient choking when the thickener applied was less than half prescribed.

104. It is ordered that the Defendant be removed from the register and the roll for a period of 3 months.

105. The Bed Bath incident involved a vulnerable patient who depended on the Defendant to take care for her. The trust was breached and hence it would be appropriate that the Defendant be removed from the register and the roll for a period of 3 months.

106. The Council accepts that the Defendant's husband, who is also a nurse, will continue to support her and that through no fault of hers, this matter has taken longer than usual, a total of 6 months' removal from the register and roll be sufficient reflection of the overall misconduct.