Nursing Council of Hong Kong

Disciplinary Inquiry under s.17(1)

Nurses Registration Ordinance (Chapter 164)

No.: NC/441/7/B

Date of hearing: 5 February 2018

Defendant: Ms. A ([redacted])

DECISION

1. Ms. A, the Defendant, is an enrolled nurse.

2. The charge against the Defendant as stated in the Notice of Inquiry dated 17 November 2017 is:

> *"That in the course of performing cervical cancer screening for Ms B ('the Patient') at the Yaumatei Maternal and Child Health Centre on 29 September 2016, you, being an enrolled nurse of the Yaumatei Maternal and Child Health Centre,*
>
> *(i) failed to check the sterilization pouch and failed to check and/or failed to ensure that the stainless steel vaginal speculum should bear a sterilization label indicating that it had been sterilized before applying*

the stainless steel vaginal speculum for performing cervical cancer screening for the Patient; and

(ii) failed to ensure individual safety in the course of practice by applying the unsterilized stainless steel vaginal speculum for performing cervical cancer screening for the Patient,

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

Burden and Standard of Proof

3. The burden of proof is always on the Legal Officer and the Defendant does not have to prove her innocence. The standard of proof for disciplinary proceedings is the preponderance of probability. The more serious the act or omission alleged, the more inherently improbable must it be regarded. Therefore, the more inherently improbable it is regarded, the more compelling the evidence is required to prove it on the balance of probabilities.

Unprofessional Conduct

4. According to section 17(3) of the Nurses Registration Ordinance, Cap. 164 ("NRO"), "unprofessional conduct" means an act or omission by a registered nurse or an enrolled nurse which could be reasonably regarded

as disgraceful or dishonourable by registered nurses or enrolled nurses of good repute and competency.

Relevant Facts

5. The Yaumatei Maternal and Child Health Centre ("YMCHC") offers cervical cancer screening service by cervical smear to women.

6. Disposable plastic vaginal speculums are used for performing cervical smear. If clinically indicated (e.g. failed examination with plastic speculums), reusable stainless steel vaginal speculums would be used.

7. According to the infection control guidelines, used stainless steel vaginal speculum would be cleaned, dried, packed into sterilization pouch and sterilized by autoclaves. After sterilization, a sterilization label would be affixed onto the sterilization pouch.

8. The routine practice in YMCHC is that sterilized stainless steel vaginal speculums are kept in a box in a dedicated room, while cleaned stainless steel vaginal speculums pending sterilization are kept in another room.

9. On 28 September 2016, a nurse misplaced one stainless steel vaginal speculum which was cleaned, packed into sterilization pouch and pending sterilization into the box which was designated for storing sterilized stainless steel vaginal speculums ("the Box").

10. On 29 September 2016, the Defendant was on duty as an enrolled nurse at YMCHC. She was responsible for performing cervical screening that day. She took a reusable stainless steel vaginal speculum from the Box to perform screening on Ms B ("the Patient"). She did not check the sterilization label and was not aware that the vaginal speculum she used on the Patient did not bear a label indicating that it had been sterilized.

11. The incident was discovered by staff of YMCHC at the end of the session on the same day when it was found out that the empty pouch did not bear the sterilization label.

Findings of Council

12. The Defendant did not give evidence at today's inquiry. The Council will not take any adverse view against her for not giving evidence.

13. The Defendant's case is that at the material time she had checked the pouch which contained the unsterilized stainless steel speculum. She said the pouch was in normal, good condition and there was no trace of pollution. She does not dispute that she had not checked if there was any sterilization label on the pouch. She also does not dispute that she had applied the unsterilized stainless steel vaginal speculum on the Patient. She claims that it was another registered nurse who had misplaced the pouch containing the unsterilized stainless steel speculum into the Box, and she therefore took it for use believing that the speculum was sterilized. She claims that she was under no duty or responsibility to check the

sterilization label before use of the equipment. She also claims that no training courses were taken in relation to the packaging of reusable medical instruments in DH Services. Therefore, she had no knowledge about checking the label to ensure sterilization of the equipment.

14. The Defendant claims that the new practice of sterilization was in force at YMCHC since around early or middle of 2016 and she had used such reusable vaginal speculums for around 5 to 6 times since implementation of the new practice. She recalled that she had attended a briefing about the new sterilization practice but only got a vague idea of the new sterilization practice. She claims that the circular "Recommendation on Packaging of Reusable Medical Instruments in DH Services" was issued by the Public Health Nursing Division of the Department of Health on 30 September 2016 ("the Circular"), which was after the subject incident.

15. The Council is of the view that it is a very basic principle that both registered and enrolled nurses should check sterilization label before the use of any sterilized items, including both disposable and reusable items in any setting. In fact, such routine check is an expected duty within the competence required of every registered and enrolled nurse.

16. In the present case, although another nurse had misplaced the pouch containing the unsterilized stainless steel vaginal speculum in the Box, the Defendant also had the responsibility to check the sterilization label and the pouch and ensure that the speculum had been sterilized before applying it on the Patient. There could be situations where sterilized stainless steel

vaginal speculums were correctly placed in the Box, but the period of sterilization had expired. The Council emphasizes that under paragraph 4.3 of the Code of Ethics and Professional Conduct for Nurses in Hong Kong, nurses are responsible and accountable for individual nursing judgments and actions. It should be the due diligence of the Defendant to check all relevant information to ensure the Patient's safety.

17. The Council considers that the Circular is irrelevant for this case because the contents focused on the packaging of Reusable Medical Instruments.

18. The Council is satisfied that the Defendant's conduct was seriously below the standard expected amongst enrolled nurses. It would be reasonably regarded as disgraceful or dishonourable by enrolled nurses of good repute and competency.

19. The Council therefore finds the Defendant guilty of unprofessional conduct under the charge.

Sentence

20. The Council considers that the Defendant had committed a serious act or omission which threatened patient safety.

21. The Council takes into account that the Defendant is of clear disciplinary record. The Council also takes into account what the Defendant submitted that she was not intentional when committing the offence and her past performance appraisal.

22. Having considered the seriousness of the offence, the Council orders that the name of the Defendant be removed from the roll for a period of one month in pursuance of s.17(1)(ii) of the NRO.

Recommendation

23. The Council recommends the Defendant to seriously revisit the core responsibilities of an enrolled nurse and actively upkeep her knowledge especially on patient safety.

Professor Agnes TIWARI

Chairman, Nursing Council of Hong Kong