Nursing Council of Hong Kong

Disciplinary Inquiry under s.17(1)

Nurses Registration Ordinance (Chapter 164)

No.: NC/279/7/B

Dates of hearing:	3 November 2015, 18 & 20 January 2016, 30 May 2016	
Defendants:	Ms. A ( )	D1
	Ms. B ( )	D2
	Ms. C ( )	D3
	Ms. D ( )	D4
	Mr. E ( )	D5
	Ms. F ( )	D6
	Ms. G ( )	D7
	Ms. H ( )	D8
	Ms. I ( )	D9
	Ms. J ( )	D10
	Ms. K ( )	D11
	Mr. L ( )	D12
	Ms. M ( )	D13

DECISION

1. D1 to D8 are registered nurses. D9 to D13 are enrolled nurses.

2. Each of D1 to D13 is charged with the following:

"That during the hospitalization of Mr. N ("the Patient") at the Kowloon Hospital ("KH") from 6 November 2011 to 14 November 2011, you, being

[a registered nurse] / [an enrolled nurse][1]*, failed to provide safe and competent nursing care to the Patient by treating the permanent tracheostoma of the Patient as a temporary tracheostomy wound, and failing to take steps to prevent putting layers of gauze and medical adhesive tape over the permanent tracheostoma in an inappropriate way, thus causing the blocking of the permanent tracheostoma, and that in relation to the facts alleged, you have been guilty of unprofessional conduct."*

3. At the hearing on 3 November 2015, of all the thirteen defendants, only D8 and D13 had made no case submission.[2]

4. The Council rejected the submission of D8. The Council upheld the submission of D13, and D13 was found not guilty of the charge.

Burden and Standard of Proof

5. The Council bears in mind that the burden of proof is always on the Legal Officer (i.e. the Prosecution) and the Defendants do not have to prove their innocence. The Council also bears in mind that 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

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[1] As the case may be, depending on whether the defendant is a registered nurse or an enrolled nurse.

[2] In respect of D8, pursuant to reg. 31(b) of the Nurses (Registration and Disciplinary Procedure) Regulations, Cap. 164A; in respect of D13, pursuant to 31(b) of the Enrolled Nurses (Enrolment and Disciplinary Procedure) Regulations, Cap. 164B.

more compelling the evidence is required to prove it on the balance of probabilities.

6. Although the cases against D1 to D12 are heard together, and they share common facts and background, the Council bears in mind that each of D1 to D12 is charged separately. The Council will consider and determine if the prosecution can prove the charge against each of D1 to D12 separately.

Unprofessional Conduct

7. The charges against D1 to D12 are charges of “unprofessional conduct”.

8. 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.

Background

9. At all material time, ward E4 of Kowloon Hospital (“KH”) was a mixed ward of surgical and medical beds. The Patient was a surgical patient. D1 to D12 (except D8) were nurses of ward E4, of which some were deployed to care for the surgical patients, and some for the medical patients.

10. The Patient was diagnosed to have suffered from pharyngeal carcinoma. Pharyngolaryngectomy was performed in Queen Elizabeth Hospital (“QEH”)

by Dr. O ("Dr. O"), and a permanent tracheostoma was created on 9 June 2011.

11. On 13 June 2011, it was discovered that the Patient suffered from a significant left ischaemic stroke.

12. On 24 June 2011, the Patient was transferred to ward E4 of Kowloon Hospital ("KH") for rehabilitation. From 24 June 2011 to 14 November 2011, there were several inter-hospital transfers between QEH and KH for various medical reasons i.e. follow up, dislodging or blockage of feeding tube (Ryle's tube).

13. During the initial post-operative period, a tracheostomy tube was inserted at the permanent tracheostoma to maintain a patent airway. The tracheostomy tube was removed on 28 October 2011 at QEH.

14. On 1 November 2011, the Patient was transferred back to KH for rehabilitation.

15. On 7 November 2011, the Patient went back to QEH due to blockage of the Ryle's tube.

16. On 8 November 2011, the Patient was transferred back to KH until he passed away on 14 November 2011.

17. Subsequently, an autopsy was performed on the Patient. According to the Autopsy Report dated 8 December 2011 ("Autopsy Report"), there was a tracheostomy opening at the suprasternal notch. It measured 2.1 cm transversely and 1.5 cm superior-inferiorly. There was a piece of gauze found in the tracheal lumen at 4.2 cm below the tracheostomy opening, extending from the mid-trachea to the left main bronchus. The gauze was soaked with sputum, measuring 7.3 cm x 1.6 cm x 1.4 cm, and had partially occluded the tracheal lumen. The direct cause of death as shown by the autopsy was said to appear to be upper airway obstruction by foreign body.

18. A death inquest in respect of the Patient was held on 25, 28 and 29 January 2013 in Case no.: CCDI 1114/2011. The Coroner found that the gauze which was trapped inside the trachea was a result of an accident, and the Patient came by his death by accident. Dr. P had provided an Expert Opinion Report dated 7 November 2012 for the purpose of the death inquest ("P's Expert Report").

19. The Hospital Authority had prepared an Investigation Report on the Management of the Tracheostomy of a Patient (Deceased) in Kowloon Hospital dated 16 March 2012 ("HA's Investigation Report"). The HA's Investigation Report was to investigate the management of the Patient's tracheostomy during his stay in KH, the last office for the Patient, and the Patient's relatives' other complaints.

Prosecution's case against D1 to D12

20. In brief, the prosecution's case is that D1 to D12 were nurses of KH during the period from 6 November 2011 to 14 November 2011. Since the tracheostomy tube of the Patient was removed on 28 October 2011, the wound of the Patient should have been well formed by the period from 6 November 2011 to 14 November 2011. D1 to D12 all lacked awareness that the wound was a permanent tracheostoma, which they all should have been able to realize. By having failed to realize that the wound was a permanent tracheostoma, and instead treating it as a temporary one, and by failing to take steps to prevent putting layers of gauze and medical adhesive tapes over the wound in an inappropriate way, thus causing blocking of the permanent tracheostoma, D1 to D12 had thereby failed to provide safe and competent care to the Patient, and which amounted to unprofessional conduct.

21. The Prosecution had called three witnesses at the inquiry – Mr. Q, the son of the Patient ("PW1"); Madam R, wife of the Patient ("PW2"); Mr. S (transliteration), a close friend of the Patient ("PW3").

22. PW1's evidence in brief is that on 6 November 2011 he visited the Patient at KH. PW1 saw the Patient's stoma covered with gauze and strapped on four sides. He therefore enquired with D10 about his observation that the Patient's dressing was being strapped on four sides, and expressed his concern about the blocking of Patient's airway. PW1 provided D10 with his contact details, and had requested to see the doctor. PW1 also said that on 13 November 2011 at around 6 p.m. when he visited the Patient at KH he had made a

complaint to D6 in relation to the strapping of the wound on four sides, and his concern about the blocking of the Patient's airway. PW1 said he had also provided his contact details to D6 as D6 had indicated that she had to ask the doctor about the matter. PW1 said that on 14 November 2011 after the Patient passed away, his immediate reaction was to find the gauze at the scene, as he suspected that the cause of death of the Patient was due to the inappropriate strapping of the gauze.

23. PW2's evidence in brief is that since the Patient was transferred back the second time to KH after the removal of the tracheostomy tube, but she could not remember exactly when, she had seen the Patient's stoma being strapped on four sides. She said she saw plenty of yellowish sputum on the gauze.

24. PW3's evidence in brief is that during the period from 6 November 2011 to 14 November 2011 he had visited the Patient a number of times, and he said on one of the occasions when he visited the Patient, he had seen the Patient's stoma being strapped on four sides. PW3 also said that he noted there were plenty of sputum stuck to the inside layer of the gauze.

<u>Defendants' cases</u>

25. Each of D1 to D12 had previously made written submission to the Preliminary Investigation Committee ("PIC").

26. The Council notices that common amongst a number of the defendants is that they raise one or more of the following defences:

(i) That they were misled by the discharge summary of QEH dated 8 November 2011 ("QEH Discharge Summary") and/or by the Observation Chart of KH ("Observation Chart").

(ii) That the Patient's vital signs were stable either all along or after change of dressing, and that the Patient had no dyspnea, shortness of breath, and breathing difficulties.

(iii) That they either just replicated the wound dressing method of QEH or that of the last dressing.

(iv) That the doctor(s) who conducted the ward rounds for the Patient had not indicated that their dressing method was inappropriate.

(v) That there was no guideline for dressing the stoma after the removal of the tracheostomy tube.

27. At the inquiry, D1 and D3 gave evidence. The rest of the defendants did not give evidence. D1 to D12 had not called any independent witness.

28. D1's evidence in brief is that when the Patient was being transferred from QEH to KH on 8 November 2011, she saw the Patient's wound strapped on both upper and lower sides. She told the Council that on 12 November 2011 when she changed dressing for the Patient's wound, she covered the wound

with one piece of gauze and strapped it on four sides. Her evidence was also that when she received the Patient on 8 November 2011 she found no medical record indicating that the Patient had a permanent tracheostoma. Further, D1 told the Council that the vital signs of the Patient were normal. The Council notes that when D4's counsel cross-examined D1 at the inquiry, D1 was asked if she would have strapped the Patient's stoma around all sides had she known that the Patient's operation was laryngectomy. D1 said she would not.

29. D3's evidence in brief is that there was no guideline on tracheostomy care. D3 also said that on 10 November 2011 she was the runner and she supervised a pupil nurse to change the Patient's dressing. She said that she followed the previous dressing method and strapped the Patient's wound with a gauze consisting of four layers (4-ply) on four sides. D3 also said that the vital signs of the Patient on 10 November 2011 were stable.

<u>Council's views</u>

30. Before moving on to deal with each individual case against D1 to D12, the Council would first endeavor to set out our views on the following matters:

(i) on the defences commonly raised by a number of the defendants;

(ii) on nurses' knowledge about pharyngolaryngectomy;

(iii) on the Patient's wound status from 6 November 2011 to 14 November 2011;

(iv) on “layers of gauze” ;

(v) on how the Patient’s tracheostoma was strapped between 6 November 2011 and 14 November 2011; and

(vi) on blocking of permanent tracheostoma

Council’s views on the defences commonly raised by a number of the defendants

31. On the defence that the nurses were misled by the QEH Discharge Summary and/or by the KH Observation Chart. The QEH Discharge Summary wrote “transferred to KH for rehabilitation, on tracheostomy”. The Council finds it reasonable that the nurses by referring only to the QEH Discharge Summary, and nothing else, would take it to mean that the wound was a temporary tracheostomy, and not a permanent tracheostoma. The KH Observation Chart recorded “Dressing to Trach Site Daily”. The Council is unable to tell from these words that it would mean the wound was a permanent tracheostoma. The Council finds the QEH Discharge Summary and the KH Observation Chart misleading. However, whether a nurse was actually misled by the QEH Discharge Summary and/or by the KH Observation Chart would depend on the facts and circumstances of each individual case.

32. On the defence that the Patient’s vital signs were stable either all along or after change of dressing, and the Patient had no dyspnea, shortness of breath, and breathing difficulties. According to P’s Expert Report, “as the gauze

seemed only to be changed once a day in the morning, it is possible that it became saturated with sputum/mucus as time progressed. While it is possible to breathe through a dry piece of gauze, it is not possible to breathe through gauze saturated with mucus. In that case, the sputum soaked gauze would behave like a piece of plastic in that it would be totally impervious. In the patient's frail state, and with a weak right arm the patient may simply have tried harder and harder to breathe with deeper and increasing inspiratory efforts rather than to remove the piece of gauze himself and in that way remove the obstruction to his breathing. Eventually the patient may have inspired or aspirated the gauze during one of his labored inspiratory efforts. This would have left to a respiratory arrest." The Council agrees with Dr. P's view that airway blockage takes time to develop as a patient has to breathe through the gauze which, as time goes by, sputum will build up and when the gauze is soaked with sputum, there will be the risk of airway blockage. The fact that the vital signs of the Patient remained stable all along or after dressing could not therefore exclude the risk of airway blocking.

33. On the defence that some of the nurses either just replicated the wound dressing method of QEH or that of the last dressing, the Council cannot accept simply following how the wound was dressed by other colleague as the basis of independent clinical judgment for patient care. It is always a nurse's professional responsibility to exercise his/her clinical judgment in the execution of nursing care.

34. On the defence that the doctor(s) who conducted the ward rounds for the Patient had not indicated that the nurses' dressing method was inappropriate, the Council cannot accept simply relying on the views of other profession as the basis for the decision of patient care. It is always a nurse's professional responsibility to exercise his or her clinical judgment in the execution of nursing care.

35. On the defence that there was no guideline on tracheostomy care, the Council is of the view that while guidelines are statements of recommendations intended to optimize patient's care, it is always a nurse's professional responsibility to exercise his/her clinical judgment in the execution of nursing care.

<u>Councils' views on nurses' knowledge about pharyngolaryngectomy</u>

36. Dr. O gave evidence at the death inquest. Dr. O said that when health care professionals saw from the medical record the term "pharyngolaryngectomy", they should have known that the patient has a permanent tracheostoma. The Council agrees with Dr. O. The Council takes the view that nurses, both registered nurses and enrolled nurses, should know that when a patient has undergone "pharyngolaryngectomy", the patient would have a permanent tracheostoma. The care thus provided to the patient should be that of a permanent tracheostoma care.

<u>Council's view on the Patient's wound status from 6 November 2011 to 14 November 2011</u>

37. Dr. P's expert views on the possible explanation for the gauze in trachea was general in nature, and not specific about how he thought was the wound status of the Patient between 6 November 2011 and 14 November 2011. Similarly, Dr. O's statement about the differentiation between permanent tracheostoma and temporary tracheostomy was general in nature, and not specific about the Patient's wound status between 6 November 2011 and 14 November 2011. Dr. T, who performed cardiopulmonary resuscitation ("CPR") on the Patient on 14 November 2011, although said at the death inquest that "由於個病人係--個氣管係--已經係同個皮膚已經縫合咗㗎喇", yet what she said was about the suturing of the trachea to the skin, and had not indicated specifically about the status of the Patient's wound. The Autopsy Report only indicated the size of the tracheostoma ("[t]here was a tracheostomy opening at the suprasternal notch. It measured 2.1 cm transversely and 1.5 cm superior-inferiorly. No stitches or adhesive tapes were found on the surrounding skin."). It has no information on the status of the wound of the Patient.

38. The Council therefore finds no evidence to show the status of the Patient's wound from 6 November 2011 to 14 November 2011. Unless and until there is documentation to show clearly to the Council the status of the Patient's wound, the Council cannot be sure of the status of the Patient's wound from 6 November 2011 to 14 November 2011. Unless the Council knows the exact status of the wound from 6 November 2011 to 14 November 2011, the Council cannot be certain if a nurse at the time was able to differentiate if the wound was permanent or temporary by merely looking at it.

Council's views on layers of gauze

39. The Council considers that one piece of gauze has four layers (that is 4-ply). In HA's Investigation Report, a majority of the nurses in their staff interviews also confirmed that one piece of gauze has four layers (that is 4-ply). Therefore, the Council is of the view that putting "layers of gauze" means putting one or more pieces of 4-ply gauze.

40. Whether the nurses had put layers of gauze or had failed to prevent putting layers of gauze will depend on the facts and circumstances of each individual case against each of the Defendant, and also had to be looked at together with how the wound was strapped with medical adhesive tapes. The Council will deal with this point when dealing with each of the Defendant's case individually in the following.

Council's views on how the tracheostoma was strapped between 6 November 2011 and 14 November 2011

41. PW1 said he had complained to D10 about his concern regarding the strapping of the gauze on four sides and the possible blockage of the Patient's airway on 6 November 2011. D10 never gave evidence before the Council. D10 had cross-examined PW1. D10 put to PW1 that he only wanted to consult doctor to make enquiries about the Patient's health condition. PW1 denied and said he had specifically complained to D10 about his concern about the strapping of the four sides of the gauze. PW1's evidence is consistent all along with what he said to the police in his statement on 13 December 2011 and with his evidence given at the death inquest. PW1's

evidence was unshaken when cross-examined by D10 at the inquiry. The Council finds PW1 honest and reliable. The Council accepts that on 6 November 2011 when PW1 visited the Patient at KH, the Patient's gauze was being strapped on four sides.

42. PW2's and PW3's evidence to the Council was that sometime during the period from 6 November 2011 to 13 November 2011, the Patient's tracheostoma was covered with gauze and strapped on four sides. PW2 and PW3 were however not sure on what exact dates they saw the tracheostoma being covered with gauze on four sides. The Council finds PW2 and PW3 honest and reliable, and accepts their evidence.

43. At the inquiry, D3 told the Council that she had supervised a pupil nurse to strap four sides of the gauze on 10 November 2011.

44. D1 told the Council that she had strapped the gauze on four sides on the tracheostoma on 12 November 2011.

45. At the death inquest, D4 gave evidence. D4 told the court that she had strapped four sides of the gauze after suctioning on 13 November 2011. D5 had given a witness statement to the police dated 10 September 2012. In his witness statement, D5 said that he had performed wound dressing on the Patient on 13 November 2011 and he strapped four sides of the gauze. Further, PW1 told the Council at inquiry that when he visited the Patient again on 13 November 2011, he had still seen that the wound was being

strapped on four sides. He told the Council that he was very angry and made a complaint to D6 about why the wound was still strapped on four sides. The Council believed this is why on 14 November 2011 after the Patient had passed away, PW1's immediate reaction was to find the gauze at the scene as he suspected that the cause of death of the Patient was due to the inappropriate strapping of the gauze thus causing blocking of the Patient's airway. The Council finds that the Patient's wound was strapped on four sides on 13 November 2011.

46. The Council therefore finds that the Patient's tracheostoma was strapped on four sides on 6, 10, 12 and 13 November 2011.

47. However, for 7 November 2011, the Patient was not in KH, and for 8, 9 and 11 November 2011, there is no evidence to show how the Patient's wound was being strapped.

<u>Council's views on blocking of permanent tracheostoma</u>

48. *<u>On how the gauze was strapped with adhesive tape</u>*

(i) According to P's Expert Report, "[a] tracheal stoma is NEVER covered with gauze. It can either be left open without any dressings in the vicinity, or a laryngectomy bib or laryngectomy apron can be worn around the neck of the patient. This acts as a heat moisture exchanger and prevents sputum from being coughed into the patient's surroundings should the patient cough. The laryngectomy

bib is so large, it covers the entire anterior neck, that it would be impossible ever to aspirate it in the trachea."

(ii) According to HA's Investigation Report, "[i]n permanent tracheostomy, after the tracheostomy tube is removed, the hole is left open and will not close. It is common practice to not cover the hole, because the patient needs to breathe through that hole. However, it is also acceptable for the stoma to be covered with one piece of gauze with strapping at upper edge of the gauze or with tracheostomy napkin (one edge fastened only), for cosmetic reasons or prevention of foreign body entering the trachea. Because only one edge is fixed and the other edge is loose, the patient's breathing will not be obstructed."

(iii) Having considered the views of Dr. P and the Hospital Authority, the Council takes the view that it is best not to cover the tracheostoma with gauze. However, it is also acceptable for the tracheostoma to be covered with one piece of gauze with strapping at upper side because it can (a) prevent foreign matters from entering into the trachea; and (b) allow the sputum to be coughed out.

49. *On Presence of Sputum*

(i) As explained in paragraph 32 above, the Council agrees with Dr. P's view that airway blockage takes time to develop as a patient has to breathe through the gauze which, as time goes by, sputum will build up

and when the gauze is soaked with sputum, there will be the risk of airway blockage.

(ii) According to the Autopsy Report, there was a piece of gauze found in the tracheal lumen of the Patient which was soaked with sputum.

(iii) PW2's and PW3's evidence were that during the period from 6 November 2011 to 13 November 2011, they saw plenty of sputum on the Patient's gauze.

(iv) According to the Patient's Treatment Sheet dated 11 November 2011 (1540 hours), it was recorded that suctioning was provided by D1. According to the Patient's Treatment Sheet dated 12 November 2011 (1130 hours), it was recorded that suctioning and dressing were done by D1.

(v) According to the Patient's Treatment Sheet dated 13 November 2011 (0300 hours), it was recorded that frequent suctioning was performed by D4.

(vi) According to the Patient's Treatment Sheet dated 13 November 2011 (1030 hours), D2 recorded that "Sputum ++ Suction done". The "++" sign indicates that there were plenty of sputum.

(vii) The fact that there were records of suctioning done from 11 November 2011 to 13 November 2011 had demonstrated that the Patient could have built up an increasing amount of sputum during that period.

50. The Council is of the view that all the evidence showed that (i) some of the nurses covered the tracheostoma with gauze and strapped the gauze on four sides on 6, 10, 12 and 13 November 2011; and (ii) during 11 to 13 November 2011 the Patient had built up an increasing amount of sputum. The Council's view is that strapping the gauze on four sides in such a way that sputum cannot be coughed out by the patient from the tracheostoma is an inappropriate way of managing the care of a permanent tracheostoma. It is highly unlikely that the patient would be able to cough out the sputum when the gauze was strapped on four sides, hence leading to the risk of airway blocking.

Findings of the Council on each of the charges against D1 to D12

51. The Council will now individually consider and determine each of the charges against D1 to D12.

D1 (Ms. A)

52. According to D1's statement to the police dated 25 May 2012, D1 was registered as a Registered Nurse (General) in early September 2011. She was transferred to E4 ward of KH in mid-September 2011. D1 said in her statement that she had participated in caring for the Patient since mid-October 2011. D1 said that the Patient had a tube in the tracheostoma when

she first approached the Patient. D1 also indicated that she had provided suctioning and changed the gauze of the tracheostoma wound for the Patient.

53. D1 also said in the statement that after the tracheostomy tube was removed on 28 October 2011 she had changed dressing for the Patient twice. The first occasion D1 said was that on a date she could not remember, whilst she changed the dressing, she was aware that the dressing was covered with a double-folded square gauze which was strapped on both upper and lower sides. She then followed the same method to secure the dressing. The second occasion D1 said was that on 12 November 2011 she had observed that the dressing was strapped on four sides. She had also observed that there was sputum on the gauze. D1 then changed the dressing and covered the tracheostoma with a new gauze and strapped it on four sides.

54. According to the Staff Roster and Responsibilities/Duties from 6/11/11 to 14/11/11 of Hospital Authority's Report dated 16 March 2012 ("Staff Roster") and the treatment sheets, D1's responsibilities/duties during the period from 6 November 2011 to 12 November 2011 were as follows:

(i) On 6 November 2011, D1 was the Patient's shift in-charge, providing basic care to the Patient and checking his vital signs.

(ii) On 8 November 2011, D1 received the Patient when he was transferred back from QEH and she recorded on the treatment sheet as "dressing on old TT site intact and dry".

(iii) On 9 November 2011, D1 was the Patient's shift in-charge and had provided basic care to the Patient

(iv) On 10 November 2011, D1 was the Patient's shift in-charge.

(v) On 11 November 2011, D1 was the Patient's shift in-charge. Suctioning and basic care were provided by D1.

(vi) On 12 November 2011, D1 was the Patient's shift in-charge. Suctioning was provided and dressing was performed by D1.

55. The treatment sheets also show that D1 had nursed the Patient on 2, 4 and 5 November 2011 for various nursing care procedures such as suctioning and dressings.

56. When D1 was cross-examined by D4's counsel at the inquiry and asked if she had known that the Patient's operation was laryngectomy whether she would have strapped the Patient's stoma around four sides. D1 said she would not. From the medical records, the Council notices that there was a Nursing Kardex of KH created on "08/11/2011 13:43" and printed on "08/11/2011 13:45" ("Nursing Kardex"). The Nursing Kardex form shows the name stamps of D1, and purportedly with her signature. The Council has reasons to believe that this form was created by D1 on 8 November 2011 at around 13:43 hours or 13:45 hours. In this Nursing Kardex, it was clearly indicated therein that the Patient had undergone an operation on 9 June 2011

of "Pharyngolaryngectomy as part of the pharyngo-laryngo-oesophagectomy (30.3) flap". This operation means that the Patient's pharynx and larynx were removed. According to P's Expert Report, "[a] total laryngectomy (laryngectomy) involves the removal of the larynx (voice box)…The larynx is also divided from the pharynx which is closed primarily or with a flap, or the larynx and pharynx are both removed if a laryngectomy and pharyngectomy is performed. In either case, the cut end of the trachea is then sutured to the skin of the lower neck for its entire circumference. The patient now permanently breathes through his hole in the centre of his lower neck…" The Patient clearly had pharyngolaryngectomy performed. As laryngectomy is part and parcel of pharyngolaryngectomy, D1 must have knowledge that laryngectomy had been performed. There should not be any excuse that D1 would not have known that laryngectomy was performed. As such, D1 should not have strapped the Patient's stoma on four sides on 12 November 2011.

57. In her submission to the PIC, D1 claimed that when the Patient was transferred back from QEH on 8 November 2011, and after the wound was strapped on four sides on 12 November 2011, the Patient's vital signs including blood pressure, heart rate, blood oxygen saturation level remained stable with no signs of breathing difficulty, shortness of breath or hypoxia. Therefore, D1 was of the view that there was no blockage of the Patient's airway after strapping the Patient's wound on four sides. However, the Council stresses that, whilst already dealt with above, airway blockage takes time to develop as a patient has to breathe through the gauze which, as time

goes by, sputum will build up and when the gauze is soaked with sputum, there will be the risk of airway blockage. The fact that the vital signs of the Patient remained stable after dressing by D1 on 12 November 2011 could not therefore exclude the risk of airway blockage. The Council also takes the view that strapping the gauze on four sides in such a way that sputum cannot be coughed out by the Patient from the stoma is an inappropriate way for managing the care of a permanent tracheostoma. It was highly unlikely that the Patient would be able to cough out the sputum when the gauze was strapped on four sides, hence leading to the risk of airway blockage.

58. D1 also indicated that sputum was found and suction was performed before dressing was done on 12 November 2011. If there was sputum and suction was performed, this already indicated signs of blocking of the airway and the Patient was at risk of suffocation. Maintenance of clear airway is critical in the delivery of nursing care. It is unreasonable to continue to secure the four sides of the gauze in this situation especially when the Patient had had a stroke and was unable to communicate his needs both physically and verbally effectively.

59. D1 also claimed in her statement to the police dated 25 May 2012 that there was no specific guideline on nursing care of patients with tracheostoma, and that she had not been taught or supervised to do this care procedure. D1 at the inquiry further claimed that she had just followed the wound dressing method of QEH when the Patient was transferred in to KH on 8 November 2011. Again, as already dealt with above, the Council cannot accept simply

replicating how the wound was dressed by QEH as the only basis of independent clinical judgment for patient care. That there was no guideline was not an excuse. While guidelines are statements of recommendations put forward to optimize patient's care, it is always a nurse's professional responsibility to exercise his/her clinical judgment in the execution of nursing care. Whether or not there was guideline, a nurse should still have conducted a thorough assessment upon admission or transfer-in of patients in order to identify patient's actual or potential problem and ensure that deliberate steps are carried out to avoid omissions and premature conclusion in the provision of patient care.

60. According to the treatment sheets, on 11 November 2011 D1 had performed suctioning for the Patient. According to D1's statement to the police and the treatment sheets, on 12 November 2011, D1 had performed both suctioning and dressing for the Patient and had strapped on four sides of the gauze.

61. The Council's view is that on 12 November 2011, D1, having put a gauze with four layers (according to Council's view at paragraphs 39 and 40 above) over the tracheostoma and strapped the gauze on four sides in such a way that sputum cannot be coughed out by the patient from the tracheostoma, is an inappropriate way for managing the care of a permanent tracheostoma. It is highly unlikely that the patient would be able to cough out the sputum when the gauze was strapped on four sides, hence leading to the risk of airway blockage.

62. The Council is satisfied that D1's conduct was seriously below the standard expected amongst registered nurses. It would be reasonably regarded as disgraceful or dishonourable by registered nurses of good repute and competency.

63. The Council therefore finds D1 guilty of unprofessional conduct under the charge.

<u>D2 (Ms. B)</u>

64. According to the Staff Roster, D2 was the Patient's shift in-charge nurse on 6, 8, 9, 12 and 13 November 2011 with care provided to the Patient. D2's responsibilities/duties on 9 November 2011 was to supervise a pupil nurse to perform dressing.

65. When a nurse is assigned as the patient's shift in-charge nurse, he/she is responsible and accountable for the provision and coordination of care of that patient. He/she is to ensure that appropriate care be given to the patient in that shift of duty. To fulfill this duty, the Council's view is that the nurse should have thorough understanding of the patient's background and condition. In this case, the Council expects that when a nurse is being assigned as the patient's shift in-charge nurse for the first time after the Patient was transferred back from QEH on 8 November 2011, it is of fundamental importance that he/she should read through all relevant documents of the Patient, including but not limited to the Discharge Summary, Nursing Kardex, Observation Charts, Treatment Sheets and Vital Signs

Observation Charts. It is also of fundamental importance that the patient's shift in-charge nurse has to observe the patient's dressing condition whenever he/she is performing general care (for example, turning position, performing Ryle's tube feeding) or specific care (for example, suctioning) to the patient.

66. As mentioned above, the Nursing Kardex was created by D1 on 8 November 2011 at around 13:43 hours or 13:45 hours. In the Nursing Kardex, it was clearly indicated therein that the Patient had undergone an operation on 9 June 2011 of "Pharyngolaryngectomy as part of the pharyngo-laryngo-oesophagectomy (30.3) flap". On 8 November 2011, D2 was on duty at the "pm" shift. D2 was the Patient's shift in-charge nurse for the first time after the Patient was transferred back to KH. The Council takes the view that D2, being the Patient's shift in-charge nurse on 8 November 2011, should have read through the Nursing Kardex. Had D2 properly discharged her duty and responsibility by reading through the Nursing Kardex, she would have known that the Patient's wound was a permanent tracheostoma, and not a tracheostomy. The Council therefore cannot accept D2's claim, as set out in her submission to the PIC, that she was misled by the medical records of QEH, which had not indicated that the Patient's tracheostoma was a permanent one.

67. D2 also claims in her submission to the PIC that they would take the wound dressing method of QEH as reference and followed the same way to cover the wound. As already said, the Council cannot accept simply following how the wound was dressed by QEH as the basis of independent clinical

judgment for patient care. It is always a nurse's professional responsibility to exercise his/her clinical judgment in the execution of nursing care.

68. In her submission to the PIC, D2 claimed that the Patient's condition was stable with no breathing difficulties during her provision of daily general care to the Patient. However, according to the Patient's Treatment Sheet dated 13 November 2011 (1030 hours), D2 recorded that "Sputum ++ Suction done". The "++" sign indicates that there were plenty of sputum. The Council stresses that, whilst already dealt with above, airway blockage takes time to develop as a patient has to breathe through the gauze which, as time goes by, sputum will build up and when the gauze is soaked with sputum, there will be the risk of airway blockage. The fact the Patient had no breathing difficulties could not therefore exclude the risk of airway blockage.

69. D2 said that she had not provided direct care to the Patient's wound. The Council does not accept this claim. According to the Staff Roster, D2's responsibilities/duties on 9 November 2011 was to supervise a pupil nurse to perform dressing. According to the Treatment Sheet dated 9 November 2011, D2 recorded "DX done", which means dressing was done. However, the Council cannot identify any evidence on how the dressing was being strapped.

70. At paragraph 46 above, the Council already finds that the Patient's wound was strapped on four sides on 6, 10, 12 and 13 November 2011. D2 was on

duty on “pm” shift on 12 November 2011. D2 was on duty on “am” shift on 13 November 2011. D2 was the Patient’s shift in-charge nurse on both 12 and 13 November 2011. On both 12 and 13 November 2011, D2 had performed general care (i.e. turning and changing napkins) and special care (i.e. suctioning) on the Patient. As the Patient’s shift in-charge nurse, and when performing general and special care on the Patient on both 12 and 13 November 2011, it is of fundamental importance that D2 should observe the Patient’s dressing condition. D2 should have observed that on both 12 and 13 November 2011, the Patient’s wound was dressed with gauze and strapped on four sides. D2 should therefore have taken steps on both 12 and 13 November 2011 to prevent the Patient’s tracheostoma from being strapped on four sides. However, it could be seen that no step was taken by her, because if she had taken steps, when PW1 visited the Patient in the afternoon on 13 November 2011 he would not have complained that the Patient’s wound was still strapped on four sides. The Council is satisfied that D2 had failed to take steps to prevent putting layers of gauze and medical adhesive tape over the Patient’s tracheostoma in an inappropriate way.

71. The Council has already explained at paragraphs 48 to 50 above and is satisfied that the blocking of the permanent tracheostoma was thereby caused.

72. The Council is satisfied that D2’s conduct was seriously below the standard expected amongst registered nurses. It would be reasonably regarded as

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

73. The Council therefore finds D2 guilty of unprofessional conduct under the charge.

D3 (Ms. C)

74. According to the Staff Roster, D3's responsibilities/duties on 10 November 2011 was to supervise a pupil nurse to perform dressing on the Patient. D3 was the night nurse in-charge on 11 November 2011 with care provided to the Patient.

75. D3 told the Council that the care that she provided to the Patient was based on information from the QEH Discharge Summary which stated the Patient was "on tracheostomy", and on information from the Observation Chart. D3 was of the view that the Patient's wound was a temporary tracheostomy wound. Therefore, when she supervised the pupil nurse to change wound dressing on 10 November 2011, she had treated the wound as a temporary tracheostomy wound. D3 also told the Council that she had supervised the pupil nurse to strap the gauze on four sides.

76. D3 told the Council that she was the runner on 10 November 2011. As a runner, D3 had reviewed the Observation Chart together with the pupil nurse before wound dressing. D3 told the Council that the chart indicated to them "Dressing to Trach-site Daily". As said, the Council is unable to tell from

the words “Dressing to Trach-site Daily” that it meant the wound was a permanent tracheostoma. D3 also told the Council that before the dressing she found the Patient’s wound was in a satisfactory condition with no sputum and no other foreign matters blocking the wound. The Council is satisfied that D3, as a runner on duty on 10 November 2011, had accessed the appropriate accessible information before the wound dressing procedure. The Council is of the view that D3 had dressed the wound based on information collected from the QEH Discharge summary and the Observation chart, which had not indicated that the wound was a permanent tracheostoma.

77. Being misled by the information from the QEH Discharge Summary and the Observation Chart, it is reasonable that D3 would not have doubted that the wound was not a temporary one. Therefore, she would not have found out that the wound was a permanent tracheostoma.

78. There is also no information provided to the Council that D3 had performed any wound care or suctioning when performing her night duty on 10 November 2011.

79. The Council is therefore not satisfied that there is sufficient evidence to establish the charge against D3.

80. The Council is therefore not satisfied that D3 had failed to treat the permanent tracheostoma of the Patient as temporary tracheostomy wound and to take necessary steps to prevent putting layers of gauze and medical adhesive tape over the permanent tracheostoma in an inappropriate way.

81. Therefore the Council finds D3 not guilty of the charge.

D4 (Ms. D)

82. According to the Staff Roster, D4's responsibilities/duties on 6 November 2011 was the night nurse in-charge, on 10 November 2011 the ward nurse, and on 13 November 2011 the night nurse in-charge.

83. D4 had given evidence at the death inquest. D4 told the court that after she had performed suctioning for the Patient on 13 November 2011, she had covered the stoma with two pieces of gauze, and then strapped them on four sides with micropore.

84. D4's case is that she was being misled by the word "tracheostomy" that had been used in the medical record. There is no evidence that D4 had provided any wound care to the Patient from 6 November 2011 to 12 November 2011. D4 did not give evidence before the Council. The Council has no evidence as to what documents or information D4 had referred to before performing suctioning on 13 November 2011. There is also no evidence to rebut what D4 claimed that she was merely referring to the medical record which shows that the wound was a tracheotomy. The Council will give D4 the benefit and treat it that D4 had dressed the wound based only on information from the medical record that the wound was a tracheostomy. This word "tracheostomy" has not indicated that the wound was a permanent

tracheostoma. The Council believes that it has misled D4 to think that it was a temporary one.

85. In view that D4 was misled by the information from the medical record, it is reasonable that she would not have doubted that the wound was not a temporary one. Therefore, she would not have found out that the wound was a permanent tracheostoma.

86. The Council is therefore not satisfied that there is sufficient evidence to establish the charge against D4.

87. The Council is therefore not satisfied that D4 had failed to treat the permanent tracheostoma of the Patient as temporary tracheostomy wound and to take necessary steps to prevent putting layers of gauze and medical adhesive tape over the permanent tracheostoma in an inappropriate way.

88. Therefore, the Council finds D4 not guilty of the charge.

D5 (Mr. E)

89. According to the Staff Roster, D5's responsibilities/duties on 13 November 2011 was a ward nurse who had performed dressing for the Patient.

90. According to D5's witness statement to the police dated 10 September 2012, he worked in ward E4 of KH which was a mixed ward of medical and surgical beds since 19 September 2011. D5 explicitly stated that he served

mainly those medical patients. D5 claimed that he had never been the Patient's shift in-charge nurse, nevertheless, he had provided general nursing care such as feeding, turning position and changing diapers for him.

91. There is no evidence to show that D5 had knowledge of the Patient's stoma was a permanent one when he was on duty on 13 November 2011. Therefore, there is no evidence to show that D5 had treated the permanent stoma as a temporary one.

92. On 13 November 2011 at around 9 a.m., it was the first time for D5 to perform wound dressing for the Patient, and he strapped the four sides of the gauze. D5 in his submission to the PIC said that he performed the dressing according to the prescription on the Observation Chart. The Council is unable to tell from the Observation Chart that there is any information indicating that the wound was a permanent tracheostoma. Based on the information collected by D5 before the wound dressing, the Council is of the view that D5 had dressed the wound based on the information collected from the Observation Chart, which had not indicated that the wound was a permanent tracheostoma. The Council is satisfied that D5 was misled by the limited information from the Observation Chart. It is reasonable that he would not have doubted that the wound was not a temporary one. Therefore, he would not have found out that the wound was a permanent tracheostoma.

93. The Council has gone through all the records adduced in this inquiry. The Council is satisfied that D5, as not a core nursing staff member to take care

of the Patient, had accessed the appropriate accessible information before the wound dressing procedure.

94. The Council is therefore not satisfied that there is sufficient evidence to establish the charge against D5.

95. The Council is therefore not satisfied that D5 had failed to treat the permanent tracheostoma of the Patient as temporary tracheostomy wound and to take necessary steps to prevent putting layers of gauze and medical adhesive tape over the permanent tracheostoma in an inappropriate way.

96. The Council therefore finds D5 not guilty of the charge.

D6 (Ms. F)

97. According to the Staff Roster, D6 was on duty only on 13 November 2011, and her responsibilities/duties on that day was the ward in-charge nurse who was approached by the Patient's son for enquiry.

98. PW1's evidence to the Council was that on 13 November 2011 he had specifically complained to D6 about the fact that the Patient's dressing was strapped on four sides and queried if this would have affected the Patient's breathing as sputum could not be coughed out. As said, the Council finds PW1 an honest and reliable witness, and accepts what PW1 said.

99. In her submission to the Council, D6 said that she had replied to PW1's enquiry that she would ask the doctor in the ward round on the next day. D6 also indicated that she was handling other patients which required her immediate nursing attention at the time of PW1's enquiry.

100. According to the evidence presented to the Council, D6 had not delivered any direct care to the Patient since 28 October 2011 when the tracheostomy tube was removed until 14 November 2011. There is no evidence to show that D6 had knowledge that the Patient's stoma was a permanent one when she was on duty on 13 November 2011. There is therefore no evidence to show that D6 had treated the permanent stoma as a temporary one.

101. The Council is therefore not satisfied that there is sufficient evidence to establish the charge against D6.

102. The Council is therefore not satisfied that D6 had failed to treat the permanent tracheostoma of the Patient as temporary tracheostomy wound and to take necessary steps to prevent putting layers of gauze and medical adhesive tape over the permanent tracheostoma in an inappropriate way.

103. The Council therefore finds D6 not guilty of the charge.

D7 (Ms. G)

104. According to the Staff Roster, D7's responsibilities/duties on 14 November 2011 was the night nurse in-charge (i.e. duty hours from around 2100 hours on 13 November 2011 to around 0630 hours on 14 November 2011) who found the Patient developed cardiac arrest, involved in cardiopulmonary resuscitation ("CPR") and handling of the Patient's relatives. In her submission to the PIC, D7 said that between 6 to 13 November 2011 she was responsible for the care of the medical patients in E4 ward, and D7 had not provided any wound care or suctioning to the Patient during this period.

105. According to the Staff Roster, during the period from 6 November 2011 to 14 November 2011, D7 was only on duty on 14 November 2011. No evidence shows that D7 had nursed the Patient from 6 November 2011 to 13 November 2011. The Council is satisfied that no one had ever provided to D7 any relevant information about the Patient's condition during the handover on 14 November 2011. There is also no evidence to show that PW1's complaint to D6 on 13 November 2011 had been brought to the attention of D7. The Council is also satisfied that D7 had never provided any wound care or suctioning to the Patient on 14 November 2011.

106. The Council is therefore not satisfied that there is sufficient evidence to establish the charge against D7.

107. The Council is therefore not satisfied that D7 had failed to treat the permanent tracheostoma of the Patient as temporary tracheostomy wound

and to take necessary steps to prevent putting layers of gauze and medical adhesive tape over the permanent tracheostoma in an inappropriate way.

108. The Council therefore finds D7 not guilty of the charge.

D8 (Ms. H)

109. According to the Staff Roster, D8's responsibilities/duties on 14 November 2011 was the night patrol nursing officer involved in cardiopulmonary resuscitation ("CPR") and handling of the Patient's relatives (i.e. duty hours from around 2100 hours on 13 November 2011 to around 0630 hours on 14 November 2011).

110. According to the Staff Roster, during the period from 6 November 2011 to 14 November 2011, D8 was only on duty on 14 November 2011. No evidence shows that D8 had provided any direct care to the Patient from 6 November 2011 to 13 November 2011. D8's duty on 14 November 2011 was looking after 8 wards, including the ward that the Patient stayed, and there was no hands-on care on the Patient provided by D8. The Council is satisfied with D8's claim that she had not received any report about the Patient's condition on 14 November 2011.

111. The Council is therefore not satisfied that there is sufficient evidence to establish the charge against D8.

112. The Council is therefore not satisfied that D8 had failed to treat the permanent tracheostoma of the Patient as temporary tracheostomy wound and to take necessary steps to prevent putting layers of gauze and medical adhesive tape over the permanent tracheostoma in an inappropriate way.

113. The Council therefore finds D8 not guilty of the charge.

D9 (Ms. I)

114. According to the Staff Roster, D9 was the escort nurse on 7 November 2011 upon the Patient's transfer to QEH. D9 was the Patient's shift in-charge nurse on 10, 11 and 13 November 2011 with care provided.

115. The Council repeats that when a nurse is assigned as the patient's shift in-charge nurse, he/she is responsible and accountable for the provision and coordination of care of that patient. He/she is to ensure that appropriate care be given to the patient in that shift of duty. To fulfil this duty, the Council's view is that the nurse should have thorough understanding of the patient's background and condition. In this case, the Council expects that when a nurse is being assigned as the patient's shift in-charge nurse for the first time after the Patient was transferred back from QEH on 8 November 2011, it is of fundamental importance that he/she should read through all relevant documents of the Patient, including but not limited to the Discharge Summary, Nursing Kardex, Observation Charts, Treatment Sheets and Vital Signs Observation Charts. It is also of fundamental importance that the patient's shift in-charge nurse has to observe the patient's dressing condition whenever

he/she is performing general care (for example, turning position, performing Ryle's tube feeding) or specific care (for example, suctioning) to the patient.

116. As stated above, the Nursing Kardex was created by D1 on 8 November 2011 at around 13:43 hours or 13:45 hours. In the Nursing Kardex, it was clearly indicated therein that the Patient had undergone an operation on 9 June 2011 of "Pharyngolaryngectomy as part of the pharyngo-laryngo-oesophagectomy (30.3) flap". On 10 November 2011, D9 was on duty at the "pm" shift. D9 was the Patient's shift in-charge nurse for the first time after the Patient was transferred back to KH. The Council takes the view that D9 being the Patient's shift in-charge nurse on 10 November 2011 should have read through the Nursing Kardex. Had D9 properly discharged her duty and responsibility by reading through the Nursing Kardex, she would have known that the Patient's wound was a permanent tracheostoma, and not a tracheostomy.

117. At paragraph 46 above, the Council already finds that the Patient's wound was strapped on four sides on 6, 10, 12 and 13 November 2011. D9 was on duty on "pm" shift on 10 November 2011. In her submission to the PIC, D9 stated that she had provided general care to the Patient on 10 November 2011. As the Patient's shift in-charge nurse on 10 November 2011 and 13 November 2011, and when performing general care on the Patient, it is of fundamental importance that D9 should observe the Patient's dressing condition. D9 should have observed that on 10 November 2011 and 13 November 2011, the Patient's wound was dressed with gauze and strapped on

four sides. D9 should therefore have taken steps on 10 November 2011 and 13 November 2011 to prevent the Patient's tracheostoma from being strapped on four sides. The Council is satisfied that D9 had failed to take steps to prevent putting layers of gauze and medical adhesive tape over the Patient's tracheostoma in an inappropriate way.

118. The Council has already explained at paragraphs 48 to 50 above and is satisfied that the blocking of the permanent tracheostoma was thereby caused.

119. The Council is satisfied that D9'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.

120. The Council therefore finds D9 guilty of unprofessional conduct under the charge.

D10 (Ms. J)

121. According to the Staff Roster, D10's responsibilities/duties on 9 November 2011 was the night nurse who had provided care to the Patient.

122. In her submission to the PIC, D10 claimed that she had not worked for the surgical beds of the ward from 6 November 2011 to 14 November 2011. D10 stated that she had turned the Patient during her night duty on 9

November 2011. D10 further told the Council that she had never provided any wound care to the Patient from 6 November 2011 to 14 November 2011.

123. The Council is satisfied that D10 had never provided any wound care or suctioning to the Patient on 9 November 2011. The Council cannot be satisfied that D10 had failed to provide safe and competent care to the Patient by treating the permanent tracheostoma as a temporary tracheostomy wound.

124. On 6 November 2011, PW1 made an enquiry with a nurse about the Patient's wound being strapped on four sides. At the inquiry before the Council, D10 confirmed with the Council that she had received an enquiry from PW1 on 6 November 2011, and she had written down the contact information of PW1. According to D1's witness statement to the police dated 25 May 2012, D1 confirmed that D10 had passed PW1's enquiry to her. The Council is satisfied that D10 had reported PW1's enquiry to D1 who was the Patient's shift in-charge during that duty shift.

125. The Council is therefore not satisfied that there is sufficient evidence to establish the charge against D10.

126. The Council is therefore not satisfied that D10 had failed to treat the permanent tracheostoma of the Patient as temporary tracheostomy wound and to take necessary steps to prevent putting layers of gauze and medical adhesive tape over the permanent tracheostoma in an inappropriate way.

127. The Council therefore finds D10 not guilty of the charge.

D11 (Ms. K)

128. According to D11's submission to the PIC, D11 claimed that she had supervised a pupil nurse to perform dressing for the Patient on 9 November 2011.

129. However, according to the Staff Roster, it was recorded that D11 supervised a pupil nurse to perform dressing on the Patient on 11 November 2011, and was the night nurse providing general care to the Patient on 12 November 2011. There is also no record identifying D11 was on duty on 9 November 2011.

130. Although D11 had supervised the pupil nurse to perform dressing on 11 November 2011, there is no evidence to show how the dressing was changed, and how the gauze was strapped. There is no evidence to show that D11 had treated the permanent tracheostoma as a temporary tracheostomy wound. There is also no evidence to show that D11 had failed to take steps to prevent dressing the permanent tracheostoma in an inappropriate way and causing blocking of the stoma.

131. The Council is therefore not satisfied that there is sufficient evidence to establish the charge against D11.

132. The Council is therefore not satisfied that D11 had failed to treat the permanent tracheostoma of the Patient as temporary tracheostomy wound and to take necessary steps to prevent putting layers of gauze and medical adhesive tape over the permanent tracheostoma in an inappropriate way.

133. The Council therefore finds D11 not guilty of the charge.

D12 (Mr. L)

134. According to the Staff Roster, D12 was the night nurse on 14 November 2011 involved in the cardiopulmonary resuscitation ("CPR") of the Patient (i.e. duty hours from around 2100 hours on 13 November 2011 to around 0630 hours on 14 November 2011).

135. Record also shows that D12 had only provided general care to the Patient on 14 November 2011.

136. There is no evidence to show that D12 had provided wound care or suctioning to the Patient between the period from 6 November 2011 to 14 November 2011.

137. The Council is therefore not satisfied that there is sufficient evidence to establish the charge against D12.

138. The Council is therefore not satisfied that D12 had failed to treat the permanent tracheostoma of the Patient as temporary tracheostomy wound

and to take necessary steps to prevent putting layers of gauze and medical adhesive tape over the permanent tracheostoma in an inappropriate way.

139. The Council therefore finds D12 not guilty of the charge.

Professor Diana LEE

Chairman, Nursing Council of Hong Kong

Nursing Council of Hong Kong

Disciplinary Inquiry under s.17(1)

Nurses Registration Ordinance (Chapter 164)

No.: NC/279/7/B

Dates of hearing: 3 November 2015, 18 & 20 January 2016, 30 May 2016, 13 June 2016

Defendants:	Ms. A ( )	D1
	Ms. B ( )	D2
	Ms. C ( )	D3
	Ms. D ( )	D4
	Mr. E ( )	D5
	Ms. F ( )	D6
	Ms. G ( )	D7
	Ms. H ( )	D8
	Ms. I ( )	D9
	Ms. J ( )	D10
	Ms. K ( )	D11
	Mr. L ( )	D12
	Ms. M ( )	D13

SENTENCING

1. The Council will consider the sentencing in respect of D1 (Ms. A), D2 (Ms. B) and D9 (Ms. I) individually.

2. The Council bears in mind that the purpose of a disciplinary order is not to punish the defendant. The purpose of a disciplinary order is to protect the public from persons who are unfit to practise nursing, and to maintain public confidence in the nursing profession by maintaining its professionalism and upholding its good reputation.

D1 (Ms. A)

3. D1 is a registered nurse. She has a clear record. The Council notes that D1 was newly qualified as a registered nurse at the material time.

4. The offence committed by D1 is serious and the unprofessional conduct in this inquiry is related to the blocking of a permanent tracheostoma which is the airway of the Patient. However, the Council accepts that D1 was not intentional when committing the offence.

5. The Council takes note that D1 has actively participated in Continuing Professional Development ("CPD") courses. The Council is satisfied that D1 has been upgrading her professional knowledge and skills in nursing in a continuous manner.

6. D1 has submitted a number of letters in mitigation giving good remarks of her clinical performance, integrity and character. The letters have demonstrated that D1 is a responsible and dedicated nurse.

7. The Council accepts that D1 has shown remorse and has learned a hard lesson, and the likelihood of re-offending is low.

8. The Council was told and accepts that D1 has a strong passion for nursing.

9. Having regard to the gravity of the charge and the mitigating factors, the Council makes the following orders:

   (a) D1's name be removed from the register for one month;

   (b) the order in sub-paragraph (a) above be published in the Gazette

<u>D2 (Ms. B)</u>

10. D2 is a registered nurse. She has a clear record.

11. The offence committed by D2 is serious and the unprofessional conduct in this inquiry is related to the blocking of a permanent tracheostoma which is the

airway of the Patient. However, the Council accepts that D2 was not intentional when committing the offence.

12. The Council takes note that D2 has a good CPD record.

13. The Council believes that D2 has learned a lesson, and the likelihood of re-offending is low.

14. D2 has submitted a number of letters in mitigation giving good remarks of her clinical performance, integrity and character.

15. Having regard to the gravity of the charge and the mitigating factors, the Council makes the following orders:

    (a) D2's name be removed from the register for one month; and

    (b) the order in sub-paragraph (a) above be published in the Gazette

D9 (Ms. I)

16. D9 is an enrolled nurse. She has a clear record.

17. The offence committed by D9 is serious, and the unprofessional conduct in this inquiry is related to the blocking of a permanent tracheostoma which is the airway of the Patient. However, the Council accepts that D9 was not intentional when committing the offence.

18. The Council takes notes that D9 has a good CPD record, indicating that she has actively attempted to improve her knowledge and skills in nursing.

19. D9 has shown remorse and has learned a hard lesson. The likelihood of re-offending is low.

20. D9 has submitted a number of letters in mitigation giving good remarks of her clinical performance, integrity and character. D9 has shown to the Council her enthusiasm and passion in nursing.

21. Having regard to the gravity of the charge and the mitigating factors, the Council makes the following orders:

    (a) D9's name be removed from the roll for one month; and

    (b) the order in sub-paragraph (a) above be published in the Gazette.

Other Remarks

22. As always, the Council would like to uphold that provision of safe and competent nursing care is the cornerstone of the nursing profession. A nurse is therefore always held responsible and accountable for his/her individual nursing judgments and actions. A nurse should also ensure that there is no action or omission of responsibility that is detrimental to the interest and safety of his/her patients. A nurse must therefore acknowledge any limits of personal knowledge, skills, and competency, and takes steps to remedy any relevant deficits in order to meet the evolving demands of the scope of professional nursing practice.

Professor Diana LEE

Chairman, Nursing Council of Hong Kong