Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Meeting
Tuesday 5 September – Friday 8 September 2023

Virtual Meeting

Name of Registrant:	**Alinka Marx Drewniak**
NMC PIN	95C1344E
Part(s) of the register:	Registered Nurse – Sub-part 1 Mental health Nursing, Level 1 – 2 March 1998
Relevant Location:	Nottingham
Type of case:	Misconduct
Panel members:	Fiona Abbott (Chair, Lay member) Kim Bezzant (Registrant member) Alice Robertson Rickard (Lay member)
Legal Assessor:	John Caudle
Hearings Coordinator:	Maya Khan
Ms Drewniak:	Not present and not represented
Facts proved:	1, 2, 3, 4, 5a, 5b, 7, 8 and 9
Facts not proved:	6
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent by recorded delivery and first-class post to Ms Drewniak's registered address on 27 July 2023.

The panel accepted the advice of the legal assessor.

The panel took into account the Notice of Meeting which contained the correct information in accordance with the Rules.

In light of all of the information available, the panel was satisfied that Ms Drewniak has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered nurse:

1. On 14 December 2017, supplied Patient A with 28 days' worth of medication when you should have supplied them with 7 days' worth of medication

2. On 11 January 2018, failed to document the administration of a depot injection to an unknown patient

3. On 30 January 2018, administered 50mg of Risperdal Consta to Patient B when you should have administered 10mg of Paliperidone

4. On 27 April 2020, supplied Patient C with 21 days' worth of medication when you should have supplied them with 7 days' worth of medication

5. On 1 May 2020:

> *a. Amended Patient C's medication card to reflect the 21 days' worth of medication you supplied to them without a doctor changing their prescription,*

b. Asked Dr A to change Patient C’s prescription to a supply of 21 days’ worth of medication

6. Your conduct at charge 5.a was dishonest, in that you intended for anyone reading Patient C’s medication card to believe that the correct prescription was 21 days’ worth of medication when it was actually 7 days

7. Your conduct at charge 5.b lack integrity, in that you were attempting to retroactively correct the prescription you supplied to Patient C

8. On 5 May 2020, told Colleague A that Dr A had agreed to increase Patient C’s prescription from 7 days to 21 days’ worth of medication when they had not

9. Your conduct at charge 8 was dishonest, in that you intended for Colleague A to believe that Dr A had agreed to change Patient C’s prescription when they had not

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

Background

Ms Drewniak was referred to the NMC on 6 August 2020 by the Operational Manager for Adult Mental Health at Nottinghamshire Healthcare NHS Foundation Trust (the Trust).

The referral sets out concerns regarding Ms Drewniak’s medication administration and medication errors in 2017 and 2018 that were investigated locally and led to a final written warning for 24 months following a disciplinary hearing in October 2018. A further medication error occurred on the 27 April 2020, resulting in the referral to the NMC.

The details of the allegations are as follows:

- On 14 December 2017, Ms Drewniak gave 28 days’ worth of medication to Patient A instead of 7 days. Patient A should have been given smaller amounts of medication due to a risk of overdose.

- On 11 January 2018, Ms Drewniak failed to document the administration of a depot injection. As a result of this, a second dose was administered to the patient.
- On 30 January 2018, Ms Drewniak administered the incorrect depot injection to Patient B. She should have administered 10mg of Paliperidone, however she administered 50mg of Risperdal Consta instead. The 50mg of Risperdal Consta was prescribed for another patient. Ms Drewniak became aware of her mistake on the same day, contacting her manager and Patient B's family.
- On 27 April 2020, Ms Drewniak supplied Patient C with 21 days' worth of medication instead of 7 days. On 1 May 2020, Ms Drewniak noticed that she had supplied the incorrect amount of medication. She then attempted to change the drugs card in line with the error, before asking Doctor A to change Patient C's prescription to 21 days' medication to cover her mistake.
- On 5 May 2020, Ms Drewniak told Colleague A that Doctor A had agreed to increase Patient C's medication. This was untrue, and again is alleged to have been done in an attempt to cover up her mistake.

When contacted by the NMC during the investigation of the case, Ms Drewniak acknowledged that she needed help and that she is not fit to practise, and that is why she retired early. She did not, however, respond specifically to the individual charges or concerns raised against her.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case, including the written representations from the NMC.

The panel had regard to the written statements of the following witness on behalf of the NMC:

- Colleague A: employed as the team leader of Ms Drewniak
- Colleague C: Community Psychiatric Nurse at the Trust
- Doctor A: an Honorary Consultant Psychiatrist at the Trust

The panel accepted the advice of the legal assessor.

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

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

Charge 1

"On 14 December 2017, supplied Patient A with 28 days' worth of medication when you should have supplied them with 7 days' worth of medication."

This charge is found proved.

In reaching this decision, the panel accepted Colleague A's witness statement which stated:

> *"On 14 December 2017 there was a medication error involving Patient A. This error was discovered on the 20th of December 2017. Alinka gave a four week supply of medication to Patient A who was chaotic and unsafe with more than 7 days' supply. This was due to her taking more medication than prescribed with a tendency to take all of her medication in a few days rather than as directed. In order to prevent risk of overdose we limited her supply to 7 days. The patient had significant mental health issues, difficulties engaging, she was an extremely vulnerable person who was known to throw medication out of the window."*

The panel also took into account the fact that Ms Drewniak admitted this incident at an internal disciplinary hearing, as is set out in the internal disciplinary hearing outcome letter dated 7 November 2018 from the Trust. This stated:

> *"The incident occurred on 14 December 2017 but was not discovered until 20 December 2017. You recognise that a mistake had occurred but from your*

statement and testimony you said you administered the 4 weeks as you claimed it would be difficult to ensure the patient would get sufficient medication over the Christmas holiday period. This incident was not recorded within the Ulysses incident reporting process. You provided evidence to the hearing that you made a considered decision and although you sought advice, you did not gain the permission of a duly qualified medicines practitioner."

Having regard to the evidence, the panel was satisfied that Ms Drewniak supplied Patient A with 28 days' worth of medication when she should have supplied 7 days' worth of medication and therefore found this charge proved.

Charge 2

"On 11 January 2018, failed to document the administration of a depot injection to an unknown patient".

This charge is found proved.

In reaching this decision, the panel accepted Colleague A's witness statement which stated:

'On the 11 January 20218, Alinka failed to document the administration of a depot injection. This meant that another CPN checked the medication card and went to administer the depot as the card did not show it had been administered. An IR1 was raised by [another] CPN who had administered the additional depot and she reported the error and we completed steps to ensure patient safety and informed carers. We completed extra monitoring of the patient to ensure they were not harmed...'

The panel also took into account the fact that Ms Drewniak admitted this incident at an internal disciplinary hearing, as is set out in the internal disciplinary hearing outcome letter dated 7 November 2018 from the Trust. This stated:

'You admit your error, having decided to escort the patient to the door, rather than completing the task of signing the prescription card before attending to another task.'

Having regard to the evidence, the panel was satisfied that Ms Drewniak failed to document the administration of a depot injection to an unknown patient and therefore found this charge proved.

Charge 3

"On 30 January 2018, administered 50mg of Risperdal Consta to Patient B when you should have administered 10mg of Paliperidone."

This charge is found proved.

In reaching this decision, the panel accepted Colleague A's witness statement which stated:

'On 30 January 2018 in a separate incident, Alinka administered the incorrect depot injection to the incorrect patient AG. She should've administered 10 mg Paliperidone, however she administered 50 mg of Risperdal Consta…

Alinka had entered the clinic room seen the medication and assumed it was for the Patient B. She did not check the medication, dose or check the patient details. She then administered the injection to Patient B. He was on other oral antipsychotic medication and this was potentially dangerous. Alinka realised the error later that day and raised an IR1 and came to seek the manager's assistance. We completed steps to ensure that Patient B was safe and contacted the family and completed duty of candour.'

The panel also took into account the fact that Ms Drewniak admitted this incident at an internal disciplinary hearing, as is set out in the internal disciplinary hearing outcome letter dated 7 November 2018 from the Trust. This stated:

'You were unable to provide the panel with any assurance that you have sufficient knowledge of the medication you were giving and admitted you do not look at the boxes and on this occasion made an assumption that the correct medication had been put out by another nurse, with whom you did not check...'

Having regard to the evidence, the panel was satisfied that Ms Drewniak administered 50mg of Risperdal Consta to Patient B when she should have administered 10mg of Paliperidone and therefore found this charge proved.

Charge 4

"On 27 April 2020, supplied Patient C with 21 days' worth of medication when you should have supplied them with 7 days' worth of medication**."**

This charge is found proved.

In reaching this decision, the panel accepted Colleague A's witness statement which stated:

'…On the 27 April 2020, Alinka incorrectly supplied 21 days of medication to Patient C, where seven days should have been supplied...'

The panel took into account Patient C's 'Day Patient Card and Dispensing and Administration Records' (medication card) which indicates that at the relevant time Patient C was prescribed 7 days' worth of medication at a time.

The panel also took into consideration the account given by Ms Drewniak when she was interviewed by Colleague A on 5 May 2020:

'On the 27th April 2020 you visited [Patient C] and delivered his medications reporting that you thought at the time this his usual prescription of 3 days of medication as you had 3 boxes of medications. You stated that [Patient C] usual prescription before COVID was 4 days and 3 days supply a week. Therefore you were used to giving 3 days worth of medication at a time and had not checked the medications prior to giving these to the patient.

You report that you telephoned [Patient C] on Thursday 30th April 2020 to arrange the next medication delivery believing that he would now be due a further supply of medications. The patient advised you that they had 3 weeks worth of medication.'

The panel then went on to consider the interview notes of Colleague B conducted by Colleague A dated 6 May 2020 where Colleague B reported that Ms Drewniak had admitted to supplying 21 days of medication to Patient C. The interview notes stated:

'Alinka stated that she had given 21 days of medication on 27th April 2020.'

Having regard to the evidence, the panel was satisfied that on 27 April 2020 Ms Drewniak supplied Patient C with 21 days' worth of medication when she should have supplied them with 7 days' worth of medication. The panel therefore found this charge proved.

Charge 5a

"On 1 May 2020 amended Patient C's medication card to reflect the 21 days' worth of medication you supplied to them without a doctor changing their prescription."

This charge is found proved.

In reaching this decision, the panel accepted Colleague A's witness statement which stated:

'On Monday 04 May 2020, [Colleague C] checked the [Patient C's] medication card. [Colleague C] could see that the community medication card had been altered from a seven day dispense to 21 days. Alinka had altered the card and written that she'd given 21 days' supply. Nurses aren't allowed to do this.

Alinka changed the card without prior medical advice. It wasn't discussed with a medic. She signed it. I checked with pharmacy, and they confirmed that no change had been discussed in terms of frequency of administration.'

The panel took into account the notes from the interview with Colleague C conducted by Colleague A dated 7 May 2020 which stated:

> *'[Colleague C] then checked cards on Monday 4th May. The cards are sent back to the LMHT on Mondays from the pharmacy. He was concerned to see if there were any errors…He then found [Patient C's] and could see that it had been altered and 21 days was given rather than 7 days by Alinka CPN. [Colleague C] then escalated that to Team leader on 4th May.'*

The panel considered the interview notes of Ms Drewniak conducted by Colleague A dated 5 May 2020 where Ms Drewniak made admissions to amending Patient C's medication card. It stated:

> *"You had amended the card to reflect the 21 days of medication given. You reported that you felt able to amend the community card yourself."*

The panel was satisfied that a doctor had not changed the prescription. It accepted Dr A's witness statement which stated:

> *'I discussed with her that I had not seen the patient so I was not in a position to assess the risks and the suitability of changing the prescription from 7 to 21 days.'*

Having regard to the evidence, the panel was satisfied that on 1 May 2020, Ms Drewniak amended Patient C's medication card to reflect the 21 days' worth of medication she supplied to them without a doctor changing their prescription. The panel therefore found this charge proved.

Charge 5b

> "On 1 May 2020 asked Dr A to change Patient C's prescription to a supply of 21 days' worth of medication".

This charge is found proved.

In reaching this decision, the panel considered the interview notes with Ms Drewniak conducted by Colleague A dated 5 May 2020 which stated:

> *'You stated that you discussed with Dr A if the prescription could be changed to the frequency of what you had already administered which was 21 days for future prescriptions, which you say he agreed with in principle but he did not change the community card or speak to pharmacy as he had not met Patient C.'*

The panel then went onto consider Dr A's witness statement which stated:

> *'She asked me if it was appropriate to provide medication for 21 days instead of 7 days as she thought that the risks of overdose were low and a change in frequency that the medication was being provided would be more appropriate given we were in the middle of the Covid pandemic and we were trying to reduce contact and the burden on services at the time. At the time of the call, I discussed with her that I had not seen the patient so I was not in a position to assess the risks and the suitability of changing the prescription from 7 to 21 days...'*

The panel further considered the telephone interview notes dated 7 May 2020 between Colleague A and Dr A which evidence that Ms Drewniak had asked Dr A to consider changing Patient C's prescription for 21 days. The interview notes stated:

> *'[Dr A] confirmed that Alinka had rang him on the 1st May and had asked if Patient C could be given medication for 21 days. [Dr A] had clarified that he had not seen Patient C in his clinic and was not in a position to assess the risks and suitability of changing the medication delivery from 7 to 21 days. He stated that she had reported that the risks of overdose were low and that a change in frequency would be feasible...'*

Having regard to the evidence, the panel was satisfied that on 1 May 2020, Ms Drewniak asked Dr A to change Patient C's prescription to a supply of 21 days' worth of medication. The panel therefore found this charge proved.

Charge 6

> "Your conduct at charge 5.a was dishonest, in that you intended for anyone reading Patient C's medication card to believe that the correct prescription was 21 days' worth of medication when it was actually 7 days."

This charge is found not proved.

The panel considered Patient C's medication card. On the face of the record, the panel concluded that there is no indication that the original prescription for 7 days had been altered but there is a record of the medication which was actually supplied to Patient C, namely 21 days' worth.

The panel therefore concluded that there is no evidence to indicate that Ms Drewniak had the intention to act dishonestly and mislead anyone about what the prescription originally was. Rather, the medication card reflected what had actually been supplied.

The panel therefore found this charge not proved.

Charge 7

> "Your conduct at charge 5.b lack integrity, in that you were attempting to retroactively correct the prescription you supplied to Patient C."

This charge is found proved.

The panel considered its findings in relation to charge 5b in that Ms Drewniak asked Dr A to consider changing the prescription to 21 days instead of addressing her drug error. The panel was satisfied that Ms Drewniak realised her medication error and instead of escalating the medication error, she attempted to get the prescribing doctor to amend the prescription to accord with her erroneous supply to Patient C.

The panel considered that this behaviour showed a lack of integrity in that it demonstrated a lack of trustworthiness and a willingness to place her own interests above those of Patient C. The panel therefore found this charge proved.

Charge 8

> "On 5 May 2020, told Colleague A that Dr A had agreed to increase Patient C's prescription from 7 days to 21 days' worth of medication when they had not."

This charge is found proved.

In reaching this decision, the panel considered the notes of the interview with Ms Drewniak conducted by Colleague A dated 5 May 2020 where she said she had discussed changing Patient C's prescription with Dr A and that:

> *"he agreed with in principle but he did not change the community card or speak to pharmacy as he had not met [Patient C]."*

The panel considered this evidence to be indicative of Ms Drewniak telling Colleague A that Dr A had agreed to increase Patient C's prescription when he had not. It noted that the telephone interview notes dated 7 May 2020 where Dr A

> *"clarified that he had not seen [Patient C] in his clinic and was not in a position to assess the risks and suitability of changing the medication delivery from 7 to 21 days."*

Having regard to the evidence, the panel was satisfied that on 5 May 2020, Ms Drewniak told Colleague A that Dr A had agreed to increase Patient C's prescription from 7 days to 21 days' worth of medication when they had not. The panel therefore found this charge proved.

Charge 9

> "Your conduct at charge 8 was dishonest, in that you intended for Colleague A to believe that Dr A had agreed to change Patient C's prescription when they had not."

This charge is found proved.

In reaching its decision, the panel considered the context. It noted that:

- Ms Drewniak was on a final warning due to her previous medication errors;
- Ms Drewniak became aware of her medication error in relation to Patient C; and
- Ms Drewniak had already dispensed 21 days of medication instead of 7 days to Patient C.

The panel concluded that Ms Drewniak's motivation for telling Colleague A that Dr A had already agreed with the prescription change to 21 days instead of 7 days was to mitigate her error and reduce the potential consequences for her of a further medication error.

Having regard to the evidence, the panel was satisfied that Ms Drewniak's conduct at charge 8 was dishonest, in that she intended for Colleague A to believe that Dr A had agreed to change Patient C's prescription when they had not. The panel therefore found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Ms Drewniak's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the Register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Representations on misconduct

The NMC referred to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.' It also referred to comments of Jackson J in *Calheam v GMC [2007] EWHC 2606 (Admin)* and Collins J in *Nandi v General Medical Council [2004] EWHC 2317 (Admin)*: '[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired'…'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners'.

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The NMC identified the specific relevant standards of *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (the Code) which it submitted that Ms Drewniak had breached namely sections 10, 10.3, 19, 19.1, 20, 20.2.

The NMC submitted that Ms Drewniak's actions amounted to a number of serious breaches, falling far below the standards expected in the circumstances, that would be found to be deplorable by fellow nursing professionals. Not only did she fail to administer medication safely and keep accurate records, she was dishonest, and showed a lack of integrity in an attempt to cover up her mistakes. Accordingly, the NMC submitted that her actions must amount to misconduct.

The panel accepted the advice of the legal assessor.

Representations on impairment

The NMC invited the panel to find Ms Drewniak's fitness to practise impaired.

The NMC reminded the panel to bear in mind its overarching objective to protect the public. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel was referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

It submitted that all 4 limbs of the *Shipman* test can be answered in the affirmative in this case. It submitted that Ms Drewniak:

> *a) has in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
> *b) has in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or*
> *c) has in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future*
> *d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

The NMC submitted that Ms Drewniak's actions resulted in patients being given the wrong medication, or significantly more medication than prescribed. Her failings were in fundamental nursing practice and she was dishonest in attempting to cover up these failings. It submitted that Ms Drewniak has failed to show significant insight and remediation such that she can allay fears of repetition. In her only significant engagement with the NMC, she stated that she had retired early due to her need for help, acknowledging that her fitness to practise is impaired. However, it is submitted that this amounts to limited insight at most. Ms Drewniak has failed to respond to any of the specific charges or concerns directly, stated that investigating this matter is a waste of time as she has retired, and that she will not be engaging with the process. Accordingly, she has not carried out any further training, and there remains a risk of repetition.

In respect of addressing the public interest, the NMC submitted that there is a public interest in a finding of impairment being made in this case to declare and uphold proper

standards of conduct and behaviour. The public rightly expect nurses to carry out the fundamentals of nursing, particularly medication administration and record keeping, and to act with honesty and integrity at all times.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

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

The panel was of the view that Ms Drewniak's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Drewniak's actions amounted to breaches of the Code. Specifically:

> *"**10 Keep clear and accurate records relevant to your practice***
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
> *10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
> *10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
> ***18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations***
> ***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***
> *19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*
> ***20 Uphold the reputation of your profession at all times***

20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times…”.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Ms Drewniak’s failings were very serious and did amount to misconduct.

The panel considered the medication errors in charges 1, 2, 3 and 4 and determined that these were serious failings which fell far short of the standards expected of a registered nurse. The panel also considered that the dishonesty and lack of integrity in charges 5, 7, 8 and 9 would be considered deplorable by other nurses.

The panel found that Ms Drewniak’s actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

‘In determining whether a practitioner’s fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of

the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel found that all four limbs were engaged in this case. The panel determined that Ms Drewniak's actions put patients at significant risk of harm by supplying the wrong medication and wrong amounts. The panel further determined that Ms Drewniak's actions in asking Dr A to change the prescription of Patient C after she had already supplied the incorrect amount of medication to Patient C were dishonest and lacked integrity. It concluded that if Ms Drewniak's behaviour were to be repeated, she could put patients at an unwarranted risk of harm in the future. In addition, the panel

determined that Ms Drewniak's misconduct had breached fundamental tenets of the nursing profession and had brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel noted that Ms Drewniak has had limited engagement with the NMC. The only communication it had was a written response to the NMC dated 3 August 2023 from Ms Drewniak informing the NMC that she has retired. Her response stated:

> *"Please be informed that I'm unfit to practice after all this time…I have been open about my mistakes and take full responsibility".*

Nevertheless, the panel went onto consider whether it had any evidence of remediation or insight before it today. The panel noted that despite intervention from the Trust to provide Ms Drewniak with support and training following the incidents in charges 1, 2 and 3, she made a further medication error of similar type.

Regarding insight, the panel had no evidence that Ms Drewniak has reflected on the impact of her actions or shown an understanding of how her actions put patients at risk of harm.

The panel was aware that dishonesty is extremely difficult to address. The panel has not been provided with any evidence to show that Ms Drewniak has taken steps to strengthen her practice, address the concerns identified, her behaviour or her dishonesty.

Therefore, the panel is of the view that there is a risk of repetition in this case, as Ms Drewniak does not appear to recognise the potential harm of her actions or their gravity. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind the objectives of the NMC which are to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and

protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

Given the serious nature of the charges found proved, the damage to the reputation of the profession and the very limited engagement and insight provided by Ms Drewniak, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. The panel therefore also finds Ms Drewniak's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Drewniak's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking off order. It directs the Registrar to strike Ms Drewniak off the Register. The effect of this order is that the NMC Register will show that Ms Drewniak has been struck off the Register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Representations on sanction

The NMC invited the panel to consider that a striking off order is the appropriate and proportionate sanction in this case.

The NMC submitted that taking no action and a caution order would be completely insufficient in addressing the seriousness of the charges.

It submitted that the NMC guidance makes clear that a caution order is the least restrictive sanction which will only be suitable where the nurse presents no risk to the public. Given the charges in this case, there remains significant risk to the public.

The NMC submitted that a conditions of practice order would not address the seriousness of this case, particularly given the dishonesty concerns, and lack of insight, remorse, and remediation. This gives rise to a very real risk of repetition and there are no conditions that could be formulated to address the attitudinal concerns in this case.

The NMC submitted that a suspension order would also be an insufficient sanction for this case. Ms Drewniak has failed to provide sufficient insight or remediation that would allay fears of repetition. She has failed to show insight into the seriousness of her dishonesty and lack of candour. Further, the concerns are so serious, resulting in a risk of serious patient harm to multiple patients, that Ms Drewniak’s attitude and behaviour is not consistent with continued registration.

The NMC submitted that a striking off order is the only adequate sanction in this case. NMC guidance sets out 3 key points for the panel to consider before imposing a striking off order:

> *a. Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*
>
> *b. Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not removed from the register?*
>
> *c. Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The NMC submitted that the concerns, when taken together, raise fundamental questions about Ms Drewniak’s professionalism, such that public confidence would be drastically undermined by her continued registration. These are serious, harmful, deep-seated attitudinal concerns that Ms Drewniak has failed to remedy. Amongst a variety of medication administration and record keeping errors are the much more serious concerns in which Ms Drewniak made attempts to cover up her mistake. Given these

concerns, a strike off is the only sanction that will protect the public, both colleagues and patients, and maintain professional standards.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Ms Drewniak's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, it may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel to determine whilst independently exercising its own judgement.

The panel took into account the following aggravating features:

- Conduct which put patients at risk of suffering harm;
- Lack of insight into her failings;
- Repetitive incidents over a period of time; and the
- Conduct continued despite the Trust's intervention to provide Ms Drewniak with support and training following her initial medication errors.

The panel also considered the SG regarding dishonesty and identified two further aggravating features namely:

- deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients
- direct risk to patients

According to the SG, these forms of dishonesty are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register.

The panel took into account the following mitigating features:

- The panel noted that there was some reference to Ms Drewniak's personal issues within the Trust's internal disciplinary hearing outcome letter dated 7 November 2018 where Ms Drewniak said that her personal issues may have affected her at the time of some of the incidents. However, Ms Drewniak had not provided the panel with evidence in relation to this.
- The panel noted that Ms Drewniak states that she takes full responsibility for her mistakes, although she does not elaborate further and has not provided any reflection on her actions.
- The dishonesty appears to be an isolated incident in a long career.

The panel first considered whether to take no action but concluded that this would be inappropriate as this would not protect the public nor address the public interest considerations in this case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

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

The panel next considered whether placing conditions of practice on Ms Drewniak's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Whilst the medication concerns might in theory be addressed with conditions, the misconduct found in this case also involves dishonesty which is extremely difficult to address through retraining. Furthermore, Ms Drewniak has not engaged with this regulatory process and therefore, the panel has no evidence before it to show that she would comply with any conditions.

The panel noted it had no evidence of any insight or remorse from Ms Drewniak about the potential impact of her actions on patients and the reputation of the profession.

The panel also acknowledged that Ms Drewniak has clearly stated in her written response to the NMC dated 3 August 2023 that she has now retired. The panel noted that Ms Drewniak had been retired since 2 May 2020.

The panel is of the view that there are no practical conditions that could be formulated, given the nature of the charges in this case, due to the attitudinal concerns and Ms Drewniak's failure to recognise the gravity of her actions.

Furthermore, the panel concluded that the placing of conditions on Ms Drewniak's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse and involves dishonesty.

The misconduct is not a single incident and involves attitudinal issues. The panel has found that there is an ongoing risk to patients because Ms Drewniak has not fully recognised the gravity of her actions and the potential harm her behaviour poses to patients and to the reputation of the profession. She has not provided any insight, remorse or sufficient reflection to remove this risk. She has also not provided any evidence of strengthening her practice.

In light of all the evidence the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction. The panel noted the serious breaches of fundamental tenets of profession in this case and found that Ms Drewniak's actions are fundamentally incompatible with her remaining on the Register.

The panel therefore considered a striking-off order, taking note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*

- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel concluded that Ms Drewniak's dishonesty and lack of integrity raise fundamental questions about her professionalism.

The panel was also of the view that the findings in this case were so serious that to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel therefore determined that the appropriate and proportionate sanction is that of a striking off order. Having regard to the matters it identified, in particular the risk of harm posed by Ms Drewniak and the effect of her actions in bringing the profession into disrepute, the panel concluded that nothing short of a striking off order would be sufficient in this case.

The panel considered that this order was necessary to protect the public, to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Drewniak's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

In its written representations, the NMC invited the panel to impose an 18-month interim suspension order. It submitted that an interim suspension order was necessary on the grounds of public protection and was also otherwise in the public interest.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order.

The panel therefore decided to impose an interim suspension order for a period of 18 months to cover the 28-day appeal period. The panel was of the view that 18 months would allow sufficient time for Ms Drewniak to lodge an appeal, should she wish to do so, and for any appeal to be heard and determined in full.

If no appeal is made, the interim suspension order will be replaced by the substantive striking off order 28 days after Ms Drewniak is sent the decision of this meeting in writing.

That concludes this determination.

This will be confirmed to Ms Drewniak in writing.