What context factors we think are important to know about when considering a case

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We carried out research to help us identify what factors we should take into account when we're thinking about the context an incident occurred in. We've listed these below. We've created specific context questions based on these factors to help people tell us their perspective.

During the investigation of our cases we'll routinely ask the nurse, midwife or nursing associate and their employer (if the incident happened at their place of work) these questions. We'll also think about who else can tell us about the context an incident happened in. This is particularly important if the employer and nurse, midwife or nursing associate have different views.

The factors we identified relate to three areas of context:

- The nurse, midwife or nursing associate themselves

We want to know whether there were any personal factors that may have impacted the nurse, midwife or nursing associate and how these may have affected them. Although sometimes these questions may be harder for an employer to answer, we want to give the employer the opportunity to tell us what they can.

- The working environment and culture

System pressures or the working environment can prevent nurses, midwives and nursing associates from delivering safe care. We need to understand what the environment was like and whether it was a contributing factor to an incident.

- Learning, insight and any steps the nurse, midwife or nursing associate's taken to strengthen their practice

This will help us understand how the nurse, midwife or nursing associate has responded and how this may affect our consideration of the referral. We also want to hear from the employer about what they have done to resolve any issues within a workplace. This will help us think about if we need to take wider regulatory action, such as making a referral to another regulator.

Not all context factors will be present in every case. There may also be other factors that contribute to an incident that aren't listed. If someone tells us about factors that aren't on this list, our decision makers will take them in to account by considering how these fit in with our context commitments.

We code each of the factors as this helps us analyse the information we get. We can then think about whether there are systemic issues that may need wider regulatory action.

NMC1
Past Performance
Understanding how someone has performed in the past will help us consider whether the concerns are 'out of character'.
NMC2
Health and Addiction
Physical or mental health issues could provide relevant context, and those affected may not always recognise the impact or effect.

NMC3
Protected characteristics
Discrimination, harassment or victimisation can affect people's behaviour, or be a factor in their referral.
NMC4
Communication problems
Communication problems between people can be barriers to providing the right level of care.
NMC5
Factors affecting attention
Distractions in the work environment or personal lives may mean people are unable to focus on what they are doing properly.
NMC6
Tiredness/Sleep deprivation
Excessive tiredness due to sleep deprivation can affect people's behaviour or ability to concentrate.
NMC7
Lack of breaks
Everyone needs to take breaks for their wellbeing and if they cannot, this may affect their ability to carry out tasks or concentrate.
NMC8
Emotions/Mood
Personal factors or stress can distract people from performing their roles.
PC9
Contributory factors
Sometimes a nurse, midwife or nursing associate may have to make a difficult decision or prioritise tasks or people in their care. They may feel that their actions were the only thing they could have done under the circumstances.
MA10
Analysis and impact
We want to know if the nurse, midwife or nursing associate understands what went wrong, the consequences and have taken steps to prevent this from reoccurring (if relevant).
PC11
Learning
Does the nurse, midwife or nursing associate understand what could and should have been done differently and/or how to act differently in the future to avoid similar problems happening? If so, this may reduce the risk of it happening again.
PC12
Insight and Remediation
If a nurse, midwife or nursing associate has reflected and taken steps to address any gaps in their skills, knowledge or training, they may be less likely to be an ongoing risk to people in their care.
N13
Workload
Workload or work pressures can sometimes get in the way of people providing the ideal level of care or stop them from doing the

right thing.
N14
Distractions
What was the environment like at the time of the incidents? Was it particularly busy or loud compared to normal, and could this have been distracting?
N15
Substitution
Would another trained person have done the same thing? Ifso, this suggests the act may not be the fault of the nurse, midwife or nursing associate but the situation or environment.
N16
Training and supervision
Was the nurse, midwife or nursing associate adequately trained and supported for the job they had to do?
N17
Equipment
We need to know whether equipment or systems may have contributed to an incident. It may be that the right systems or equipment weren't available, or weren't in working order.
N18
Relationships
Were there poor relationships between professional groups and what impact did this have on how people acted
N19
Custom and practice
Was there a poor team culture or were poor practices or widespread workarounds part of the working environment.
N20
Raising concerns
Could concerns be raised by staff and were they appropriately responded to.