Nursing & Midwifery Council

Fitness to practise example case studies

June 2021

We've included six example case studies. These are fictional scenarios which set out the steps a nurse, midwife or nursing associate could take to show us that they can practice safely.

They are designed to help you understand how providing us with evidence of your reflection, training and supervision, and the views of your employer and other healthcare professionals can help our decision making.

Please note these are fictional case studies

Example case study 1

Nurse A was a band 5 nurse working on an adult ward (the Ward) at a hospital. The Ward catered for pre and post-operative patients having day surgery.

During a shift, Nurse A failed to complete Patient B's pre-operative assessment documentation. It was also alleged that Nurse A failed to carry out post-operative observations on Patient B. A review of the patient documentation found that Nurse A had not recorded post-operative observations for several other patients that day.

We made some initial inquiries, looking into concerns around Nurse A's record keeping and ability to conduct observations. Nurse A provided us with the following:

- A written reflective piece.
- A certificate of completion of a time management and prioritisation course.
- A report from their manager (a band 6 senior nurse) who had subsequently supervised two of Nurse A's rounds.

In Nurse A's reflective piece, they accepted that they hadn't completed pre-operative assessment documentation or carried out post-operative observations on Patient B. They acknowledged the importance of completing assessment documentation and undertaking observations, and discussed in detail the risks posed to patients if these aren't completed or undertaken.

They explained that they had completed the observations for the other patients but didn't have time to write them down, which was supported by the outcome of the Trust investigation. Nurse A said that they had struggled to complete all the paperwork but had reflected on their caseload that day and understood that they hadn't prioritised their time effectively. Nurse A identified that this was something they found challenging.

Nurse A said that they have since completed a course on time management and prioritisation. They provided their training certificate and explained how they had been able to implement some new techniques from this training to keep on top of their workload. They described how they would work with colleagues and prioritise their workload if faced with a similar situation in the future.

The report that Nurse A supplied from their manager commented positively on Nurse A's practice, noting that all observations had been undertaken, and all assessment documentation completed appropriately. Nurse A's manager felt that Nurse A's time management had improved and had no concerns.

Outcome

We decided not to carry out a fitness to practise investigation at this stage.

Summary

In this example, Nurse A has provided evidence of how they've strengthened their practice in the areas of concern raised by the Trust. Nurse A has shown they've learned from and reflected on their mistakes, demonstrating insight. We've had evidence that they've been practising to a good standard in the relevant areas since the incident. We've also had evidence of training that's relevant to their alleged clinical failings.

In these circumstances, we were satisfied that there was no ongoing risk to the public, and that Nurse A had fully addressed the concerns. For this reason, there was no need to carry out an investigation.

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Example case study 2

Nurse A was working as a registered nurse at a hospital, employed by a trust (the Trust).

Nurse A worked on the Older Persons Unit at the hospital, where they were one of the nurses responsible for providing care to Patient M. A concern was raised by a healthcare assistant (HCA) that they had witnessed Nurse A attempt to move Patient M by themselves, when the care plan required two people to move Patient M. The HCA said the technique used was not an approved moving and handling technique, and believed it may have caused the patient pain. The Trust investigated and upheld the concerns, and made a referral to us as Nurse A resigned from their position.

After finding out about the referral, Nurse A informed us that they were looking for a new employer and would provide a fuller response in due course, and we started an investigation.

During our investigation, Nurse A confirmed that they'd found a new job at a care home, providing nursing care to elderly and infirm residents. As part of their induction, Nurse A had received comprehensive moving and handling training and taken a competency assessment. They provided evidence of this from their employers.

Nurse A provided a reflective account, disputing the concerns raised by the HCA, stating that she was mistaken in what she saw. However, Nurse A reflected that they could have explained more clearly what they were doing, and provided a detailed account of how they would ordinarily perform moving and handling in the circumstances described. They demonstrated a comprehensive understanding of appropriate moving and handling techniques and provided details of the additional training they had received as part of their induction.

Nurse A's new manager provided a report confirming they had supervised Nurse A for the first 3 months of employment, and had no concerns about their competence in this area. Nurse A was regularly required to support residents with moving, and was considered a caring nurse, popular with the residents in the home.

Outcome

Our case examiners found that there was **no case to answer** and closed the case.

Summary

Although Nurse A didn't accept the concerns relating to their moving and handling of Patient M, they provided evidence of safe practice and demonstrated insight into the concerns being raised. They were also able to supply a reference that commented positively on their practice in this area. Although there was a disagreement with the witnesses, the case didn't need to be referred to a hearing because there were no outstanding concerns with Nurse A's current fitness to practise. The concerns weren't so serious that a public hearing was needed.

Example case study 3

Nurse A was referred to us by a member of the public who raised concerns about their behaviour.

Nurse A was alleged to have shouted at a patient's relative (Relative B) during a disagreement over the patient's care plan, and to have slammed the door in Relative B's face following the argument. The following day Nurse A refused to discuss the patient's care with Relative B, calling them a 'troublemaker' and swearing at them. Relative B also alleged that on a separate occasion, Nurse A was verbally abusive and swore at one of the doctors in front of colleagues and patients.

We decided to investigate the nurse as it was a serious matter that could undermine public confidence in the nursing profession.

Nurse A provided us with a reflective piece. Nurse A also said they had held reflective discussions with colleagues about the concerns.

In their reflective piece, Nurse A apologised for their behaviour. Nurse A said they had reflected on the incident and now recognised they had let the stress of a difficult situation get to them and had behaved unprofessionally. They said that if faced with something similar in the future they would take a step back and de-escalate the situation. They also recognised that patients

and relatives can be under considerable stress, and as such it's particularly important nurses remain professional in the face of challenging behaviour.

Outcome

We decided that there was **no case to answer** but issued a **warning**.
This warning stays on the public register for 12 months.

Summary

The regulatory concerns in this case were serious. However, Nurse A was able to demonstrate through their insight and reflection that their risk had reduced. There were no concerns about their clinical competence, so Nurse A's reflections on their behaviour, and how to ensure they remained professional in line with the Code, were sufficient to demonstrate a low risk of the behaviour being repeated.

We decided that there was no need to restrict Nurse A's practice and found no case to answer, but instead issued a warning to mark publically that Nurse A's conduct was unacceptable.

Example case study 4

Nurse A was a band 5 registered nurse working at a care home (the Home).

Nurse A was alleged to have made various medication errors. These errors included failing to administer medication, calculating dosages incorrectly, and administering medication to a patient (Patient A) when the medication had already been administered.

Nurse A's employment was terminated by the Home. The Home then referred the nurse to us.

We decided to refer the case for further investigation because the concerns were serious and posed a risk to the heath of patients. Nurse A was made the subject of an interim conditions of practice order while we investigated the concerns over their ability to administer medication safely.

During our investigation, Nurse A provided us with a written reflective piece.

Nurse A accepted the concerns. They discussed the importance of accurate medication administration. Nurse A acknowledged the serious risk of harm to patients if medication dosages are missed, incorrect or given twice. Nurse A stated that they found medication administration rounds challenging, and they were sometimes overwhelmed. They said in the future if they found themselves struggling to cope they would ask for help.

Nurse A said that they had not been able to secure employment as a nurse since they stopped working for the Home. However, they had found work as a health care assistant (HCA). Nurse A provided us with a copy of the detailed action plan they had developed along with their manager to improve their competency in medication administration and regain confidence to return to practise as a nurse. They had also had reflective discussions with colleagues in relation to medication administration and their errors.

Nurse A's manager wrote a reference advising that they felt Nurse A required some additional support before they were able to practise independently, but they had worked well as a HCA and were prepared to offer them a nursing role under supervision until they were signed off as fully competent.

Outcome

We found that there was a **case to answer** in relation to the medication errors and recommended **undertakings**. Nurse A accepted these undertakings, which included a requirement to be supervised by a more senior nurse when administering medication.

Summary

Nurse A demonstrated insight into the concerns around medication errors. While Nurse A had not been employed as a nurse, they had been able to partially address the concerns through their work as a HCA and provided evidence of the steps they were taking to improve their practice.

As a result, the risk posed by Nurse A could be appropriately managed with undertakings, which still allowed Nurse A the opportunity to practise and to fully remedy the concerns.

Please note these are fictional case studies

Example case study 5

Nurse A referred themselves to us having been convicted for drink–driving.

Nurse A was stopped by police after driving erratically and colliding with another vehicle. They had initially been uncooperative and aggressive towards the police. When breathalysed at the scene, they gave a result of 110 mcg alcohol per 100ml of breath, over the legal limit of 35 mcg.

Nurse A was charged with driving while under the influence of alcohol. Nurse A pleaded guilty and was convicted. They received a fine and a suspended sentence, as they were currently serving a community order for a criminal damage offence relating to a dispute with a neighbour, which we had already been made aware of.

We decided to investigate the nurse as it was a serious matter that could undermine public confidence in the nursing profession.

Nurse A provided us with a reflective piece, and a letter from their GP confirming that there were no concerns with their alcohol use.

In their reflective piece, Nurse A explained the circumstances of their conviction, and recognised the serious risk that their actions posed to members of the public. Nurse A also acknowledged that nurses occupy a position of public trust, and that such convictions can undermine public confidence. Nurse A also provided evidence of their participation and attendance at a drink-driving rehabilitation course and reflected on what they had learned from this and the impact it had on them.

Nurse A also provided us with a signed reference from their employer, a large NHS Trust. Their line manager confirmed that Nurse A had been open and honest about their conviction from the outset, and was a competent and caring nurse. They had no concerns about their health or alcohol use that might require a referral to occupational health.

Outcome

Our case examiners decided that there was **no case to answer** but issued a **warning**. This warning stays on the public register for 12 months.

Summary

The regulatory concern in this case was serious. However, the evidence provided by Nurse A indicated a very low risk of repetition; they demonstrated insight into the concern, expressed remorse and showed they had already taken steps to address their behaviour. Although Nurse A was still subject to a live suspended sentence, the case examiners decided that it would be appropriate to allow them to return to practice without restriction, but issued a warning to mark publically that Nurse A's conduct was unacceptable.

Example case study 6

Both Midwife A and Midwife B were working as registered midwives on the maternity unit of a hospital, employed by a trust (the Trust).

Parent C attended the unit in labour, and Midwife A was initially allocated to look after them. Midwife A handed over care to Midwife B during the labour at the end of their shift. Sadly, Baby D was born in poor condition, and had to be resuscitated. Baby D was later found to have suffered a hypoxic brain injury and was diagnosed with cerebral palsy.

An investigation by the Trust found that Midwife A had failed to identify serious concerns in the cardiotocograph (CTG) measuring Baby D's fetal heartbeat, and missed the opportunity to escalate this for emergency medical intervention. Midwife A had failed to follow the Trust's 'fresh eyes' protocol for reviewing CTG traces. The investigation found that Midwife B also failed to identify these concerns or follow protocol.

The parents of Baby D referred both midwives to the NMC, and because of the serious nature of the concerns we investigated their fitness to practise. We asked the Trust for documents from its own investigations, including information about both midwives' practice.

During the Trust's investigation, Midwife B refuted the concerns being raised about their own practice, stating that Midwife A should have identified the problems and provided a comprehensive handover. Midwife B felt they had received false assurance from Midwife A that the labour was normal.

Midwife A had prepared a reflective account, in which they recognised the impact of this incident on the family, and expressed how upset they were with what happened. They explained that it was a busy shift and had mistakenly thought the CTG was normal and had not followed correct policy due to time pressures. They reflected that the 'fresh eyes' policy was in place to ensure mistakes were picked up, and they were able to demonstrate the correct approach if faced with a similar situation. Midwife A actively sought out additional training in CTG interpretation to help restore their confidence, then took, and passed, a supervised assessment.

While we were carrying out our investigation, Midwife A provided a further reflective piece and a report from their manager confirming Midwife A had since been able to apply the correct approach in a similar situation. We were informed by the Trust that Midwife B had resigned before the internal disciplinary process was complete.

Outcome

Our case examiners identified concerns with both Midwife A and Midwife B's practice during the incident in question. They decided to refer Midwife B to the fitness to practise committee, but found no case to answer for Midwife A.

Summary

Even though the outcome was very serious, the case examiners decided that, in light of their reflection and training, there was a low risk of Midwife A repeating the concerns identified and so did not need to take action. They had not been provided with any evidence from Midwife B, and felt Midwife B showed a lack of insight by not considering their own practice and seeking to blame Midwife A alone.

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