

# Code evidence report

## **Code evidence report**

This report is being published alongside the redevelopment of our Code. The aim of this report is to provide a narrative for how evidence informed the draft code, which was consulted on earlier this year. It also summarises the feedback the consultation draft received, and is intended to support the last phase of the process and ensure that the final revised Code is evidence-based.

### **The Code**

We exist to protect patients and the public through effective regulation of nurses and midwives in the UK. The central publication that underpins this work is The Code: Standards of conduct, performance and ethics for nurses and midwives (NMC, 2008). The Code represents our core standards. Nurses and midwives will be required to meet these standards when they join the register and throughout their careers. This is to ensure they continue to maintain our standards of good conduct and practice.

The current version of the Code was drafted and approved in 2007 and was implemented on 1 May 2008. It is being revised as part of our ongoing cycle of review of all our standards and guidance. The review process comprises four key stages:

1. Review of existing Code and gap analysis to inform drafting (May – September 2013)
2. Developing a draft revised Code (September 2013 – April 2014)
3. Consultation and feedback on revised draft (May - August 2014)
4. Developing a final revised Code (August – December 2014)

This report is being published at the end of the third phase and brings together the feedback and evidence that has been collected in reviewing and drafting the revised code. It will provide a base for amending the consulted draft and developing a final version.

### **Developing a revised Code**

During the development phase, the Council agreed to apply a number of guiding principles to ensure that the revised Code would:

- be fit for purpose for all our core regulatory functions including revalidation, fitness to practise procedures and registration
- be fit for purpose as the overarching professional standard(s) for those on our register, providing guidance for service users, and nurses and midwives
- be evidence based, outcome focused, measurable and support nurse and midwife appraisal processes
- reflect the accepted recommendations from recent and other relevant reports, research and current best practice from other regulators
- reflect feedback from internal and external stakeholders
- be produced in a range of formats that meet the needs of all users.

## **Evidence Sources for drafting the revised Code**

To develop a draft Code for consultation we gathered and analysed a wide range of evidence. This included, but was not limited to, secondary analysis of other regulatory codes within the healthcare sector, high profile reports, as well as an initial phase of public consultation. These are detailed below:

### **Phase one of the formal consultation on Revalidation and the Code**

The first part of the consultation was conducted by Alpha Research in the first quarter of 2014. It explored how the proposed model of revalidation could be sufficiently flexible and fit for purpose to be implemented in a variety of employment settings and scopes of practice. It also gathered some initial information to inform the development of a revised Code. The consultation involved two elements:

- a detailed questionnaire, completed mainly by professionals and organisations, launched online on our website
- a much shorter questionnaire for the general public (the *general population survey*).

### **Regulatory codes of practice within the healthcare sector**

We reviewed the codes of the other eight healthcare regulators in the UK, with particular reference to the codes of the General Medical Council (GMC) and General Dental Council (GDC). These have been recently updated and provided the most relevant information in the current regulatory environment.

### **Desk-based review of our held documentation and information**

This existing information collected was analysed and used to evaluate the current Code. This included queries, Fitness to Practise information, coroners and ombudsman reports and discussions with staff across directorates.

### **High Profile Reports in the healthcare sector**

In 2013, the government and non-governmental bodies commissioned a number of healthcare-related reviews, primarily in England. These reports have all impacted on the nursing and midwifery professions and the revising of the Code. Within this document, we focus on 3 of the key reports:

- The second report by Robert Francis following the public inquiry he chaired into events at Stafford Hospital and the mismanagement at the Mid-Staffordshire NHS Trust
- The report by Camilla Cavendish into the regulation, training and employment of Health Care Assistants
- The report by Baroness Neuberger on the Liverpool Care Pathway and the treatment of dying people

## Our Advisory Groups

We have a number of external advisory groups who represent key stakeholder groups. There are three groups who have been particularly involved in feeding into the redevelopment of the code:

- The Revalidation Strategic Advisory Group – this group provided high-level four-nation feedback for key stakeholder organisations across the nursing and midwifery professions. They detailed what they would expect to see in a revised Code from a senior strategic level.
- The Education Advisory Group – this group provided input as to the implications of a revised Code on educators, AEs and students.
- Patient and Public Engagement Forum – this group provided insight into patient and public expectations of nurses and midwives, and how these expectations could be reflected in the revised Code.

## The draft revised Code

In May 2014 the draft revised Code was made available for public comment. Below are the key differences to the existing version:

1. **Patient and public expectations** – This new section outlined patient and public expectations. It stated exactly what patients and the public can expect of nurses and midwives. The main driver for including this is our intention to put protecting patients and the public at the core of all of our activities. Making the public and patients more central to regulation activities, is seen in the revised codes for both the General Medical Council and General Dental Council. Both regulators differ slightly in their approaches, with the GMC signposting a separate public-facing document regarding expectations, and the GDC publishing a section concerning patients and the public within their code. The NMC decided to take an approach similar to that of the GDC, as it was perceived to be more in line with putting patients at the centre of its activities.
2. **Prescribing and medicines management** – This new section explicitly links to the most up to date and appropriate guidance in this area. There were a number of key reasons for this addition, including that a high incidence of fitness to practise referrals in this area. In addition, we felt that the current guidance is at risk of becoming out of date, so it would be better to include a section in the Code that links to the appropriate and up-to-date advice produced by third parties, such as the British National Formulary.
3. **Fundamentals of care** – This section emphasises that the fundamentals of care must be adhered to. This inclusion was influenced by the recommendations of Robert Francis and Baroness Neuberger in their public reports and aimed to ensure that these fundamentals are put at the centre of nursing practice.
4. **The 'duty of candour' in professional accountability** – This section details the importance of maintaining an open and honest work environment, where concerns and complaints are freely raised and the truth about performance and outcomes is shared with staff, patients, public and regulators. This was influenced by recommendations made in the Francis report.
5. **The conduct of nurses and midwives via social media channels** – This section stems from the number of social media related fitness to practise cases we receive. In the first phase of consultation, social media was the area most

frequently mentioned by respondents when asked about areas that they would like to see included in the draft Code.

6. **Taking emergency action** – This revised section is modelled on the 2008 version of the Code. It states that a nurse or midwife should only practise within their limits in an emergency, so not to put the patient at any risk.
7. **Raising Concerns** – The content on raising concerns has been brought together into a new section in the revised code. This was to align the revised Code with the re-launched 'Raising Concerns Guidance', published in 2013. This section highlights the importance of practising nurses and midwives raising concerns.
8. **Maintaining clear professional boundaries** - This section has been expanded to clarify professional boundaries, including but not limited to sexual, personal and emotional issues.

There were a number of minor changes made to the content to reflect the revised Code having five fundamental aspirations rather than four key principles as previously.

## **Evidence**

This section has two parts, the first details the key evidence sources that provided the feedback in the development of the Code. The second provides a broad summary of the feedback and primary messages around each of the eight key changes outlined above, as well as reflections on the draft revised code as a complete document.

## **Evidence Sources**

This report does not go into detail for evidence sources examined but details are provided below on the five most substantial sources that are directly referred to in this report.

We gathered information from variety of sources. These were both qualitative (focus groups, stakeholder conversations) and quantitative (online survey) and care should be taken in interpreting the evidence from these different sources. A quantitative survey has a large sample of respondents answering a series of questions. It was an open survey so anyone could respond, and our analysis showed that the profile of registrants who responded to the consultation were broadly similar to the profile of the population of registrants. Although the sample here is large, it is necessarily high level and cannot go into excessive detail. The qualitative research involved fewer people, but provided richer insight into the views of respondents. After reviewing both sets of research, we believe we have found solid evidence, on which to base decisions on the next draft of the revised Code.

## **Phase two of the consultation on Revalidation and the Code**

We commissioned Ipsos MORI to undertake the second phase of consultation, between May-September 2014. The consultation reviewed the Code and the development of the revalidation model. This report only contains the results that contributed to the development of the Code, and its findings have formed the core of this report. The consultation was comprised of quantitative and qualitative research:

**Quantitative strand:** An online response form was hosted on the NMC website, from Monday 19th May 2014 to Monday 11th August 2014, accessible by anyone who wished to provide a response. In total 1,649 individual responses were

received and 110 from organisations, including educators, employers, professional bodies, government departments, regulators and patient bodies, among others.

**Qualitative strand:** 16 discussion groups were held across the UK with nurses and midwives from a range of roles, settings, and types of employment status. Five in-depth interviews were conducted with nurses and midwives working overseas, one with an e-health nurse, and five with employers of nurses and midwives. Four deliberative events conducted with a demographically diverse range of patients and members of the public across the four countries with around 25 individuals attending each group. Interviews were also conducted with 16 organisations representing seldom heard audiences, such as elderly people and those with disabilities

### **Stakeholder events**

Over the spring and summer of 2014, we held four stakeholder summits across the UK. The summits brought together over 1,000 nurses, midwives, their leaders, educators and representatives to review the draft revised Code and the revalidation model. Only the feedback relevant to the Code is reported here.

### **Social media monitoring**

We have a Facebook page dedicated to the Code and an active Twitter feed. During the consultation period, we posted sections of the revised Code on social media, and we hosted a Twitter chat on the revised Code. We recorded participants' comments and posts.

### **An externally produced report**

*"What should Nurses be like? Children's views for the Nursing and Midwifery Council's consultation on the new Nursing Code"* – We were contacted by a new project (Pupils 2 Parliament) that was set up in July 2014 to a say in the decisions being made by Government and other national groups. We worked with the lead of the project to enable a small scale trial on the topics included in the formal consultation. Twenty children (aged 10-11) participated in the trial and were asked to vote on the key changes to the Code as well their views on three key questions – *"what would a really good nurse be like?"*, *"what would a good nurse always do?"* and *"what would a good nurse never do?"*

### **Patient and Public Engagement Forum**

In February 2014 members of our patient and public engagement forum were provided with the sections of the revised code that were specifically focused on patient and public expectations.

## Feedback – key messages

### Overall feedback

The feedback from the quantitative element from phase two of the consultation on the Code was very positive. The proportion of individual respondents indicating that the language and tone of the document was 'good' and that the document was easy to read and understand was consistently greater than 80 percent. During the first phase of consultation respondents were asked to rate the existing Code in terms of 'language and tone' and being 'easy to read and understand'. Although the scales and wording was slightly different, for both categories, between the two phases of consultation, more respondents considered the revised draft Code 'very good' option, than those commenting on the existing Code.

The qualitative research (both the consultation and stakeholder events) also provided positive feedback. You can read some of the comments below.

***"I have found the "new Code" easier to read (and) easier to understand and therefore application will be easier(...) it was thought provoking and will help me implement key elements in the care I give"*** – Response to a free text question in online consultation

***"Having read this more updated version I think I would be more likely to pick it up now because it seems so much clearer and straightforward to understand"*** – Qualitative research from phase two of the consultation (Midwife, Edinburgh)

However there was less consistency in qualitative responses. There was a clear tension for many registrants between a desire to keep the Code as concise as possible and ensuring that it is able to cover nurses and midwives in a wide variety of settings and scopes of practice. Alongside the positive comments, a number of participants expressed their concerns, with some feeling that the document was too long, open to interpretation, repetitive and poorly worded in parts. Others considered it to be unsupportive, patronising and adversarial. You can read the comments below:

***"Tends to be over wordy...clearly it's necessary to cover all aspects of each area, but I would like to see even more editing to create less verbose statements"*** - Response to a free text question in online consultation

***"The draft reads laboriously and seems to rephrase many of the same points or ideas, and thus (it is) overly long"*** - Response to the free text question in online consultation

In the discussions with nurses and midwives, there were similar themes. There was a desire to keep the Code as concise as possible, while acknowledging it needs to cover the diversity of scopes of practice. There were consistent concerns regarding the language used in the document; some felt that the use of 'You must' made the document feel punitive rather than supportive and that this was not the relationship that they wanted to have with the Code, it was suggested that the use of 'I will' would sit more comfortably with registrants.

## **Patient and public expectations**

The inclusion of a section regarding public and patient expectations was broadly welcomed. The quantitative research respondents welcomed this section with 84 percent agreeing with its inclusion. Additionally, 85 percent of nurses and midwives who felt it would be either 'fairly easy' or 'very easy' to apply this additional section to their practice.

***"It is everything you would want, if you were a patient. It is everything you would want if going into hospital and nurses and midwives should give this care expected of them"*** – Qualitative research from phase two of the consultation (Overseas midwife, Dubai)

This generally positive view was emphasised in the qualitative research. However, the feedback from the stakeholder events included some resistance to the inclusion of this section within the Code itself. Some people felt that, as the Code is a document predominantly aimed at nurses and midwives patients and public expectations might be more appropriate in a separate document (similar to the approach taken by the GMC). Both the RCN and the PSA felt the status of this section was unclear, saying that it could lead to confusion about whether or not it was a formal section of the Code and whether or not nurses and midwives were expected to abide by it.

In July 2014, the Patient and Public Forum agreed with our proposal, that the 'patient and public expectations' should remain an explicit part of the Code. This is so patients and the public could use the Code, and understand what to expect from nurses and midwives.

Gathering feedback on this section formed a significant part of the workshops conducted by Ipsos MORI with patients and members of the public. Among these groups, the views of the participants were relatively consistent confirming that the draft section reflected the key qualities expected of nurses and midwives. Through the discussions, there were five key areas that the public appeared to consider particularly important:

- a. Valuing the emotional needs of patients
- b. Creating a personalised experience for patients
- c. Developing the patient experience through communication
- d. Ensuring continuity of care and demonstrating strong team-working
- e. Behaving professionally at all times

***"Empathy and understanding is important, particularly when you're giving direction"*** – Qualitative research from phase two of the consultation (Patient/Public, Edinburgh)

The elements identified by members of the public focused on soft skills rather than practical skills or knowledge. Although these technical elements were clearly considered to be essential, patients didn't feel comfortable judging the technical abilities of nurses and midwives.

***"She should introduce herself. It makes you feel at ease. It makes you feel a bit more special as well, as if you're not just a number"*** – Qualitative research from phase two of the consultation (Patient/Public, Belfast)

This was also a topic that was covered in the small piece of research that was conducted with children by Pupils 2 Parliament. On this topic and across the board the young people echoed what adults were saying on this topic.

*"A good nurse is kind"*

*"A good nurse is good at talking with people and listening to what they say"*

*"A good nurse explains things well"*

*"A good nurse always does what they think is right for each person they are looking after"*

*"A good nurse keeps things properly confidential, and only tells other people what they need to know"* – Children's responses to the question "What would a really good nurse be like?"

## **Prescribing and medicines management**

The online consultation showed strong support for including the new paragraphs on prescribing and medicines management. We found 86 percent of individual respondents agreed with the inclusion, with 81 percent of nurses and midwives saying it would be 'fairly easy' or 'very easy' to apply to their practice.

Although the Royal College of Nursing (RCN), in its response to the consultation, welcomed the inclusion of this section they argued it should specifically reference which guidance the registrant must comply with. They also advised that any such reference should be to guidance, which is authoritative and up to date.

At the stakeholder summits, discussion focused more on the content of the section rather than whether it should be included. There was some confusion over which new paragraphs would replace the existing guidance, as well as concerns over its ambiguity. It was suggested that the section should either give further detail or be reduced and link to guidance.

The nurses and midwives who participated in the focus groups were concerned with the section regarding 'prescribing'. They felt that the section may be interpreted as only relevant to those prescribing, instead of including everyone who dispenses and administers medicines.

*"Might be better if it was separated out for those that administer – geared towards prescriber – need to split it into two clear subsections – people could bypass it where they don't prescribe"* – Qualitative research from phase two of the consultation (Senior nurse, Cardiff)

## **Fundamentals of care**

In the online consultation 83 percent of individual respondents welcomed the inclusion of the new paragraphs on the fundamentals of care. Notably, midwives and supervisors of midwives (SoMs) were significantly more likely to agree with 89 percent, than nurses or SCPHNs with 83 percent.

The section was broadly welcomed with 82 percent of nurses and midwives saying it would be 'fairly easy' or 'very easy' to apply this section to their practice.

There was considerable support for this section in the feedback from the qualitative element, with the link to the Francis report being recognised by some. While

participants generally agreed on the importance of these paragraphs in the light of recent high profile failings, there was a sense of disappointment that fundamentals of care needed to be spelled out.

*“People aren’t taught anymore how to feed people etcetera...it is a real skill. Therefore, it is important that this is included”* – Qualitative research from phase two of the consultation (Primary care nurse, Cardiff)

Some participants at the stakeholder events recognised the importance of this section, however felt it was less applicable to those who do not have patient-facing roles. There was further concern that the content was too prescriptive and a little patronising.

*“I’m a mental health nurse and I often go to people’s houses and there’s no food. I have given people the water and cereal bar from my bag before. What about that situation?”* – Qualitative research from phase two of the consultation (Senior nurse, Cardiff)

Despite strong support at the stakeholder summits, some participants argued that this section should not be included in the Code at all. Their view was that it is unnecessary, and even insulting to nurses and midwives, to include such a fundamental element of nursing in the Code. There was also continual concern raised around the term ‘basic’, that it failed to represent the complexity of fundamental care.

The Royal College of Nurses (RCN) and Unite also raised their concerns regarding the applicability of this section, with a view that it contained too much detail and was only relevant to those involved in direct patient care.

### **‘Duty of Candour’ in professional accountability**

The inclusion of the Duty of Candour was well supported by respondents in the quantitative elements of consultation. The results found that 83 percent of individuals agreed with its inclusion, compared with 82 percent of nurses and midwives, who felt it was broadly applicable to their practice.

In the qualitative elements this section was one of the more debated elements of the Code. There was concern whether the term ‘candour’ was universally understood or needed clearer definition. It was noted that different organisations have different understandings of what ‘candour’ means.

*“I think you need to stop and think ‘what does candour mean?’ It’s open to interpretation again”* – Qualitative research from phase two of the consultation (NHS Employer, Belfast)

Further concerns focused on the potential implications of this paragraph; several participants were worried about the issues of liability, whether nurses and midwives were expected to apologise in response to complaints.

### **Social Media**

Reflecting the findings from the first phase of consultation, the qualitative element of this research found 83 percent of individuals agreed with the inclusion of the new

paragraph on social media in the Code. Additionally, 85 percent of nurses and midwives felt that this paragraph would be easy to apply to their practice.

In the qualitative research, respondents generally felt that there was a need for this section, given that the internet and social media are commonly used by most registrants.

***“I hate to say it but the youngsters coming up don't always think. I think it does need to be highlighted somewhere”*** – Qualitative research from phase two of the consultation (Senior nurse, Belfast)

There was general support for the inclusion of this paragraph, with the underlying issue of some registrants not being able to separate their private lives and their working lives on social media. However, many questioned why the section prohibits people from mentioning colleagues or employers. They felt the issue would be better addressed as behaving in an ‘unprofessional manner’ or making ‘inappropriate’ references to the workplace.

This view was shared by the responses to the formal consultation from the RCN, Unite and the Shelford Group, who delivered clear examples of where nurses and midwives might refer to their organisations and colleagues, quite appropriately, on social media

In a Twitter discussion with nurses, there was similar concern that the existing paragraph could restrict freedom of expression. It was emphasised that social media could be used by nurses for positive reasons, such as sharing best practice, however it was acknowledged that some nurses misuse social media. It was suggested that we should be focus on educating nurses and midwives on the appropriate use of social media.

### **Taking emergency action**

In the quantitative elements of consultation, 83 percent of individuals agreed with the inclusion of the new paragraph on when to take emergency action. Support for these paragraphs was stronger amongst midwives and SoMs with 90 percent, than amongst nurses and SCPHNs with 83 percent. 83 percent of nurses and midwives felt this paragraph would be easy to apply to their practice.

This addition was broadly welcomed in the qualitative elements of consultation, however some felt that it would be useful to define what is meant by ‘emergency’. There was also a request to specifically detail the role of nurses and midwives in an emergency as well as concern that the current paragraph might be open to misinterpretation.

***“What if you're on a nightshift and you needed to do CPR and then I came in on the morning and they say well I didn't have the knowledge and training”*** – Qualitative research from phase two of the consultation (Care home nurse, Edinburgh)

The RCN expressed concern that the current paragraphs on ‘emergency action’ do not explain what situations these apply to. Like some of the qualitative group participants, the Professional Standards Authority (PSA) felt that the section was over cautious and may deter some registrants from taking appropriate perhaps essential, action in an emergency.

## **Raising concerns**

In the online consultation, respondents showed the highest level of support for the amended paragraphs on raising concerns, compared with the other new or amended sections, with 89 percent of individuals agreeing with its inclusion. The section was considered to be broadly applicable with 85 percent of nurses and midwives who responded indicating it would be easy to apply this section to their practice.

*“It endorses anyone who feels the need to [whistleblow]. I think paragraph 64 is really important, I think it reflects on the Francis report. I can relate to that, having moved to a new team. I think that if many of the nurses in the team had read that, it would have gone down very well.”* – Qualitative research from phase two of the consultation (Primary care nurse, Cardiff)

The stakeholder summits drew conflicting opinions regarding the inclusion of the ‘raising concerns’ section in the Code. Some participants supported the inclusion of this section, however others felt it was unnecessary as there is already guidance on raising concerns.

Feedback included the view that there needed to be a differentiation in the wording between significant concerns and routine improvements to practice. There were also comments around the need for clearer outlines, for example around the responsibilities of those with managerial and leadership roles; and lack of sufficient reference to employer obligations.

Comments from social media echoed the views expressed in the qualitative work, with some disputing whether ‘raising concerns’ should be included. There was positive feedback on the paragraph regarding the protection of whistle-blowers by leaders and managers; however others queried how, in practice, whistle-blowers could be protected from reprisals. In one Facebook discussion, several whistle-blowers told of poor treatment by senior staff when they raised concerns, which resulted in them leaving their job or the NHS.

## **Maintaining clear professional boundaries**

The online consultation showed the highest level of support for this section. Of the individuals surveyed, 87 percent agreed with its inclusion. Additionally, 87 percent of nurses and midwives felt it would be easy to apply this section to their practice.

In the qualitative elements, the paragraphs on refusing gifts, favours, hospitality and loans, were supported. However, some participants queried the extent to which this should apply to gifts, for example, if patients gave nurses a box of chocolates.

*“You have to accept gifts as that’s the patient’s thank you and they would be offended if these were refused.”* – Qualitative research from phase two of the consultation (Acute care midwife, Edinburgh)

With regards to maintaining clear professional boundaries, several respondents commented that nursing involved emotional situations. It was suggested that the wording in the draft revised Code should be amended to define what is and is not appropriate behaviour in such situations.

*“It’s impossible not to be emotionally involved and contradicts person centred care and building relationships. It’s not just being their carer...they want someone who cares...what about in a situation where baby dies?...emotional should come out”* – Qualitative research from phase two of the consultation (Midwife, Edinburgh)

The paragraph regarding ending professional relationships was criticised by participants in several of the stakeholder summits. Some argued that it may not be possible in particular situations for nurses or midwives to do this, and that the paragraph needed revising. Coupled with this feedback, the term ‘bond of trust’ was also disliked by several of the summit groups.

## **Next Steps**

This document examines the key evidence that contributed to the first three stages of development of the revised Code. In the next stage of the process, we will consider all of the evidence presented to us, and apply this to the redrafting of the new Code, ensuring that it is evidence-based.