Commitment 4: Where risks are caused by system and process failures, we'll concentrate on the action we can take to help resolve the underlying issues

Reference: FTP-12d Last Updated: 06/05/2025

The evidence is clear that even one-off events or errors are usually caused by multiple contributing factors coming together.[1] Wrongly blaming an individual won't change these factors, won't stop underlying issues happening again and ultimately won't help keep people safe.

Where systemic issues prevent nurses, midwives and nursing associates from delivering safe care, the system should be accountable. Taking action against an individual in these circumstances doesn't lead to a culture of openness and learning, may give false assurance, direct focus away from a wider problem, and cause a future public protection gap.

Genuine mistakes and errors caused by problems in the working environment are unlikely to be issues that call into question someone's fitness to practise. If the evidence shows that a similarly qualified nurse, midwife or nursing associate would have done the same thing this may indicate the root cause of the incident is not the person's fitness to practise. Examples of this could be not completing a task when staffing levels meant it would have been impossible for anyone to do it or giving out the wrong medication when the root cause was actually because of how the medication was stored or labelled.

If we know that problems in the working environment are the real source of risk, our safeguarding responsibilities may mean we'll need to work with other agencies or professionals that are better placed than us to put these problems right. This is likely to involve sharing information, which we'll always do in a proportionate way that allows us to meet our legal responsibilities and objectives.

Where the information shows system issues contributed to an incident but the actions of the nurse, midwife or nursing associate still poses a risk to either public safety, public confidence or to professional standards we may need to share information as well as take action to address the fitness to practise concerns.

1 This is often explained in the 'Swiss Cheese' model developed by Professor James Reason. See Reason JT, Carthey J, de Leval MR. Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management BMJ Quality & Safety 2001;10:ii21-ii25.