FtP strategy

A conversation about our best future

Nursing & Midwifery Council

“The best decision, to enable better, safer care for people in the future at the earliest opportunity”

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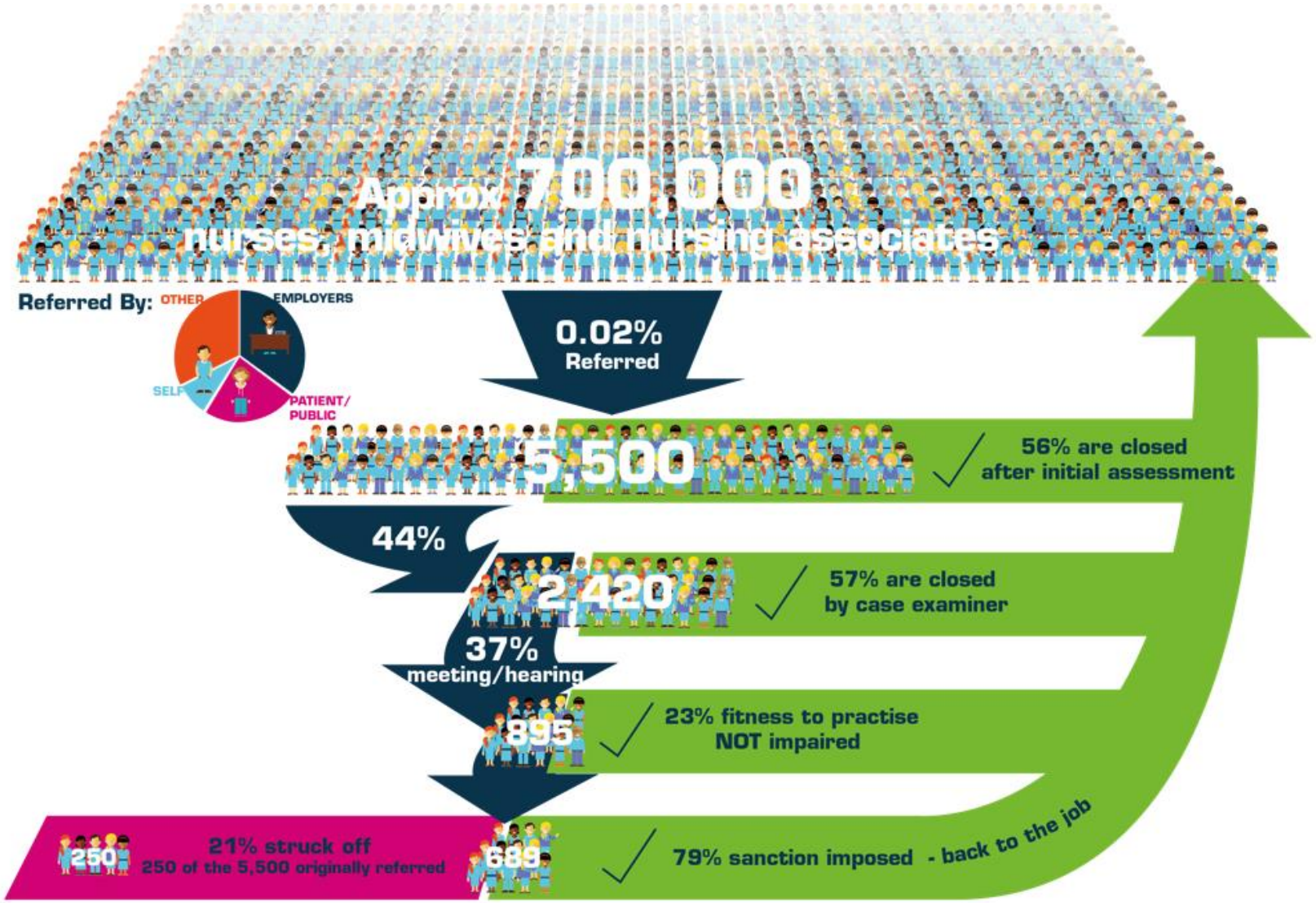
Update on the FtP strategy

Pilot Update

- Employer referrals guidance
- Support for members of the public who make referrals
- Testing a contextual factors tool
- Providing tailored remediation guidance
- Preparing statements of case



Source pg 13-18 https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/ftpannualreports/annual-fitness-to-practise-report-2017-2018-web.pdf

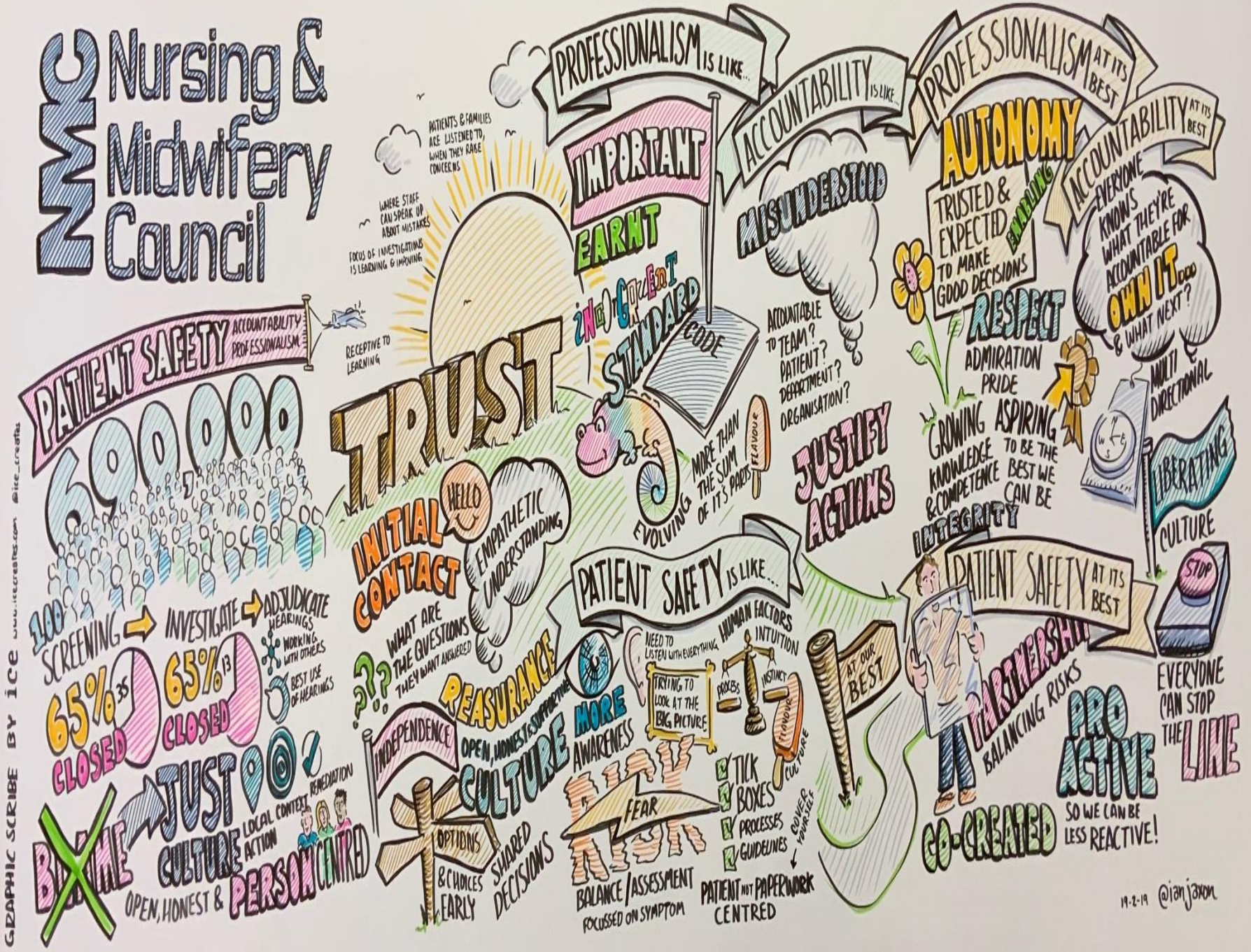
What do patients want?

Nursing & Midwifery Council

- To be truly **listened** to
- Treated with **genuine care**
- Good and clear **communication**
- An open and **fair approach**
- To know the NHS will **learn how to avoid** the same thing happening again
- **Share any learning** throughout the organisation
- Know that staff **hear what is being said and act** to improve the service and safety

the patients association

Professionalism, patient safety and accountability runs across all aspects of our FtP strategy and with each of our key stakeholders.


NMC Nursing & Midwifery Council
PROFESSIONALISM IS LIKE...
IMPORTANT
EARNT
INCONGRUENT
STANDARD
CODE
ACCOUNTABILITY IS LIKE...
MISUNDERSTOOD
PROFESSIONALISM AT ITS BEST
AUTONOMY
TRUSTED & EXPECTED TO MAKE GOOD DECISIONS
ENABLING
ACCOUNTABILITY AT ITS BEST
EVERYONE KNOWS WHAT THEY'RE ACCOUNTABLE FOR
OWN IT
& WHAT NEXT?
MULTI DIRECTIONAL
PATIENTS & FAMILIES ARE LISTENED TO, WHEN THEY RAISE CONCERNS
WHERE STAFF CAN SPEAK UP ABOUT MISTAKES
FOCUS OF INVESTIGATIONS IS LEARNING & IMPROVING
PATIENT SAFETY ACCOUNTABILITY PROFESSIONALISM
RECEPTIVE TO LEARNING
90000
TRUST
ACCOUNTABLE TO TEAM? PATIENT? DEPARTMENT? ORGANISATION?
EVOLVING
MORE THAN THE SUM OF IT'S PARTS
FLAVOUR
JUSTIFY ACTIONS
RESPECT
ADMIRATION
PRIDE
GROWING KNOWLEDGE & COMPETENCE
ASPIRING TO BE THE BEST WE CAN BE
INTEGRITY
LIBERATING
CULTURE
STOP
INITIAL CONTACT
HELLO
EMPATHETIC UNDERSTANDING
WHAT ARE THE QUESTIONS THEY WANT ANSWERED
PATIENT SAFETY IS LIKE...
PATIENT SAFETY AT ITS BEST
100 SCREENING
INVESTIGATE
ADJUDICATE HEARINGS
WORKING WITH OTHERS
BEST USE OF HEARINGS
65% 35 CLOSED
65% 13 CLOSED
REASSURANCE
INDEPENDENCE
OPEN, HONEST & SUPPORTIVE CULTURE
MORE AWARENESS
NEED TO LISTEN WITH EVERYTHING
TRYING TO LOOK AT THE BIG PICTURE
HUMAN FACTORS
INTUITION
PROCESS
INSTINCT
FAVOUR
CULTURE
AT OUR BEST
LEADERSHIP
BALANCING RISKS
PRO ACTIVE
SO WE CAN BE LESS REACTIVE!
EVERYONE CAN STOP THE LINE
TICK BOXES
PROCESSES
GUIDELINES
COVER YOURSELF
FEAR
BLAME
JUST CULTURE
LOCAL CONTEXT ACTION
REMEDIATION
OPEN, HONEST & PERSON CENTRED
OPTIONS & CHOICES EARLY
SHARED DECISIONS
BALANCE / ASSESSMENT FOCUSSED ON SYMPTOM
PATIENT NOT PAPERWORK CENTRED
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19-2-19 @ianjaxon

Story 1 – Member of the Public Referral

Principle 1: Taking a person-centred approach to fitness to practise helps us to properly understand what happened, to make sure concerns raised by patients and families are properly listened to and addressed, and to explain to them what action we can take and why

Story 1 – Summary

- A member of the public, Mrs A, called the NMC to discuss a possible referral arising from the treatment of her Mother who died in a hospital ward of a large London Trust. The referrer alleged that the cause of the death was the "neglect and abuse of nursing staff on the ward". Mrs A also highlighted that she had witnessed other patients being treated "with lack of care" and had reported her concerns to the Police.
- The Police advised that the concerns were not within their remit.
- The Trust conducted an investigation that did not result in any referrals being made. Mrs A was dissatisfied with the investigation in which she was not invited to participate and felt there had been a "cover up".
- She felt the Trust was not interested in meeting and talking with her as a bereaved relative or a potential witness. She also felt there was a lack of independent assessment of the Trust's actions.
- Mrs A is awaiting the findings of the Coroner's report which found that the cause of the death is unknown. A full forensic investigation is now in progress.
- Mrs A also reported her concerns to Social Services, and to the CQC who are investigating the case.

Story 1 – Learning

Learning for the NMC

The NMC had been working on the case but had not kept Mrs A informed of their work.

Through the new ways of working, Mrs A will receive updates on the case every 2 weeks and has had an opportunity to discuss her concerns with a case officer who has been trained to listen and conduct empathetic conversations. Mrs A reinforced how important it had been to have the opportunity to talk about her experience and concerns.

The NMC has also confirmed that although no specific action was taken against the nurses involved, individual and collective training plans have been put in place for staff working on the ward to improve the standard of care.

Potential Learning for the Trust

To engage directly with patients and their families and to give them a “voice” in local investigations; and be open and transparent in their actions and decision-making. To be clear about next steps and potential learning.

Story 2 - Our work with Context

The case study details the chronology of a case that went through the WP2 working with context pilot.

The key strategy policy principles being applied for Story 4 are:

2. Fitness to practise is about managing the risk that a registrant poses to patients or members of the public in the future. It isn't about punishing people for past events.

5. We always take regulatory action when there is a risk to patient safety that is not being effectively managed by an employer.

9. In cases about clinical practice, taking action solely to maintain public confidence or uphold standards is only likely to be needed if the regulatory concern can't be remedied.

11. Some regulatory concerns, particularly if they raise fundamental concerns about the registrant's professionalism, can't be remedied and require restrictive regulatory action.

Story 2 – Summary

Nurse J - Nurse at a care home.

Concerns about a failure to monitor and escalate a deteriorating resident who later died.

Old process

Nurse J doesn’t respond to requests for information and her reflections on the incident. The NMC is left with a concern that there is ongoing practice which could put patients at risk of harm and there’s no indication the problem has been remediated. We refer the case for further investigation.

Story 2 – Our new approach

New process

Both Nurse J and her employer returned completed context forms. These showed that:

- Nurse J had been working extra shifts to help the Home improve, and was covering for a colleague who'd called in sick at short notice.
- A number of temporary and inexperienced staff were on duty.
- Nurse J was the only member of staff on duty who could administer medication to the other residents. The new electronic medicines management system kept freezing and the medication round was taking much longer than normal.
- Nurse J did check on the resident and contacted 111 twice throughout the shift. The promised GP never arrived. She asked the care staff to alert her to any change in the resident's condition while she was carrying out the medication rounds.
- Nurse J was able to clearly explain what should have happened for the resident and there'd been no previous concerns of a similar nature.

Story 2 – the outcome

The different outcome

We concluded that Nurse J knew what needed to happen for the resident, but was prevented from doing so because of the circumstances she found herself in. In light of the context we decide the concerns do not need further investigation.

Story 3 - Our work to develop remediation

The case study details the chronology of a case that went through the FtP remediation pilot.

The strategy principles that apply in this case study are:

2. Managing the risk that a Nurse, Midwife or Nursing Associate poses to patients or members of the public in the future. It isn't about punishing people for past events.

3. We can best protect patients and members of the public by making final fitness to practise decisions swiftly and publishing the reasons openly.

7. We may not need to take regulatory action for a clinical mistake, even where there has been serious harm to a patient or service-user, if there is no longer a risk to patient safety and the registrant has been open about what went wrong and can demonstrate that they have learned from it.

9. In cases about clinical practice, taking action solely to maintain public confidence or uphold standards is only likely to be needed if the regulatory concern can't be remedied.

Story 3 – Summary

The NMC received a referral regarding Nurse B from a large UK care provider.

A resident was admitted to the care home with specific care needs due to the fact that he had pressure ulcers. He required regular pain relief. After being in the care of the home for a couple of months, the resident was admitted to hospital and died due to urinary sepsis.

A disciplinary hearing was held 2 months after the death of the resident and Nurse B was dismissed.

The NMC highlighted the following regulatory concerns:

- Failure to provide appropriate care to a resident
- Inappropriate delegation of patient care
- Not creating or maintaining an adequate care plan
- Not acting on or following a care plan

Story 3 – Outcome

Nurse B responded to the NMC stating that they had been successful in finding alternative employment.

The NMC identified that the case was suitable for the tailored remediation pilot and set out the remediation evidence that was required:

- Training in areas where deficiencies had been identified. As well as providing evidence about what Nurse B had learnt from the training and how they were putting it into practice.
- Evidence from Nurse B's employer that the concern is unlikely to be repeated. This could be a letter or report from the registrant's manager, or evidence that Nurse B had been supervised in the areas of practise about which the concern was raised.

Outcome

Evidence of remediation was submitted to the NMC by Nurse B and the case was closed.

Nursing & Midwifery Council

How can we work together?

Nursing & Midwifery Council

Thank you