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The four stages of our screening decision

Reference: SCR-1 Last Updated: 12/10/2018

We use a screening process to decide whether a case needs a full investigation. The process consists of four stages.

1. Are the concerns **serious enough** to suggest that the nurse or midwife may not be fit to practise?
2. Does the case meet our **formal requirements**?
3. Will we be able to obtain credible **evidence** about the concerns?
4. Can the nurse or midwife show **they've already remedied** any problems in their practice sufficiently so that we can be confident that any risk to patients, along with risk to public trust in nurses and midwives or professional standards, has already been dealt with?

We may not need to go through all the stages in every case.

For example if we decide at the first stage that the facts aren't serious enough to affect the fitness to practise of the nurse or midwife, we'll decide at that point that we don't need to investigate the case. In such a case the second, third or fourth stages would not be applicable.

Stage one: Determine if the concern is serious enough to affect fitness to practise

Reference: SCR-1a Last Updated: 31/08/2018

We first consider if the concern is serious enough to raise doubts on whether the nurse or midwife should be allowed to continue to practise as a registered professional, without us putting a restriction on how they work.

We use this to decide whether we need to investigate further.

For example, 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 nurse or midwife has been open about what went wrong and can demonstrate that they have learned from it.

Our [guidance on seriousness](#) explains how decision makers at our screening stage might consider the seriousness of different kinds of concerns.

There's further guidance about the different kinds of fitness to practise concern in our sections on [misconduct](#), [lack of competence](#), [criminal offending](#), [health](#), [not having the necessary knowledge of English](#), or decisions by other health or social care organisations.

Stage two: Check it meets our formal requirements

Reference: SCR-1b Last Updated: 24/05/2018

In this guide

- When is a referral in the form required?
- In writing
- Agreement to disclose and anonymous referrers
- Identifying nurses or midwives on our register
- Incidents before the nurse or midwife was registered with us
- Referrals to other regulators

When is a referral in the form required?

We are committed to operating a fair and transparent process. Before we can begin our initial consideration, any referral must:

- Be written, in a letter or an email, even if it was initially made by phone. We can assist people to do this where this is needed.
- Provide sufficient detail about the individual nurse or midwife so we are able to identify them on our register. We recognise that this is not always easy, but knowing a first name, the date and care setting in which the events took place is helpful;
- Come from a person or organisation identifying themselves by name and address, with agreement to us disclosing their referral to the nurse or midwife concerned. This is because we believe the nurse or midwife has the right to know the details of the concern and the source of the complaint, so they have the opportunity to provide a full response. We may still have to act on the information provided if there is no agreement for us disclosing the referral. This would be where it is in accordance with our regulatory processes and there is a clear public interest in us pursuing the matter further.
- Set out the nature of the concern and the events and circumstances giving rise to it, in enough detail for the nurse or midwife concerned to be able to understand and provide a response.

In writing

In order for us to consider investigating the practice of a nurse or midwife, we need to be confident that we are dealing with a precise and clear expression of the concerns involved. This means that we need the concerns to be put in writing, so that we know clearly what they relate to, and there can be no confusion about what has been referred to us.

If we first receive contact by a different method, we will advise the person contacting us of our requirement that concerns should be expressed in writing, and where the person needs us to, we will provide assistance to ensure this can be done.

Agreement to disclose and anonymous referrers

It can be difficult for us to investigate anonymous referrals. Generally, we would only do so if there would be a real risk of harm to patients if the nurse or midwife concerned was allowed to practise unrestricted.

We recognise, however, that our core function is to protect members of the public who rely on the services of nurses and midwives. For this reason, there will be cases which are so serious that it will be necessary for us to investigate, even when the person making the referral wishes to remain anonymous, does not agree that details should be disclosed to the nurse or midwife concerned, or is unknown.¹

Identifying nurses or midwives on our register

We can only investigate allegations against an identified nurse or midwife who is currently on our register². We must be confident that we have correctly identified the Personal Identification Number ('PIN') of the nurse or midwife who is the subject of a referral. We often receive complaints about care delivered to a particular patient, which tell us only that nurses on a certain ward, unit, or particular setting need to be investigated.

In cases where we need to investigate in order to identify any individual nurses or midwives concerned, we will usually ask employers or healthcare providers to supply us with documents and information (such as rotas or timesheets) from which we will be able to conclude that the referral relates to an identified nurse or midwife on our register, or more than one. We will treat cases involving a number of nurses or midwives from a particular healthcare setting (who we cannot immediately identify) as a single referral as we gather information to identify the individuals causing concern.

If after taking reasonable steps we cannot link the referral to an identified nurse or midwife on our register, we will not be able to investigate further.

Incidents before the nurse or midwife was registered with us

We will usually not investigate concerns or incidents which took place before the nurse or midwife was registered with us, unless the concern is about criminal convictions which the nurse or midwife received before they came onto our register, but did not disclose to us when they applied for registration, meaning that the correctness of their entry on our register may have been affected. There may also be exceptional cases of conduct which occurred before a nurse or midwife registered with us which, on its later discovery, may be so serious as to appear to be incompatible with continued registration, where we would carry out an investigation.

Referrals to other regulators

Where a referral does not relate to a nurse or midwife who is currently on the register, but the person concerned appears to be registered with another healthcare regulator, we will advise the person who referred the case to us that a referral to a different regulator may be appropriate. We will disclose the referral and any relevant documents to that regulator ourselves if we are asked to do so, or if we consider that this may be necessary to protect patients or others from harm.

Similarly, where a referral does not raise concerns about the fitness to practise of a nurse or midwife, but appears to raise serious issues of patient harm which should be investigated by another body (such as a systems regulator or ombudsman), we will provide that body with the appropriate information and advice. This may include disclosure of the referral and any documents to assist with consideration of the case.

1 Article 22(6) of the Nursing and Midwifery Order 2001 gives us the power to carry out an investigation into the fitness to practise, or entry in the register, of a nurse or midwife where an allegation is not made to us under article 22(1) but it appears to us that there should be such an investigation. Accordingly, we may decide to carry out an investigation in the absence of an identified referrer, or agreement to disclose the allegation to the nurse or midwife.

2 Article 22(1) of the Nursing and Midwifery Order 2001 refers to allegations against 'a registrant', which is defined in Schedule 4 as 'a member of the profession of nursing or midwifery who has been admitted to the register...'

Stage three: Check whether we can obtain credible evidence

Reference: SCR-1c Last Updated: 31/08/2018

In this guide

- Obtaining credible evidence
- If the employer hasn't finished their investigation

Obtaining credible evidence

Once we're satisfied that a referral discloses concerns that are sufficiently serious to be treated as an allegation of impaired fitness to practise or of incorrect or fraudulent entry to the register, we'll consider the supporting evidence.

We assess if there's enough evidence that's likely to be credible and admissible.

Where allegations are made anonymously by an individual who is the only witness to the alleged events, or where the only direct witness is not willing to cooperate with our investigation, more evidence will be required in order to support the concerns.

We will not be able to continue with an investigation if there's no indication of evidence that is likely to be admissible.

Examples of useful supporting evidence

Useful supporting evidence will usually include:

- a clear and logical narrative explaining the conduct which is being alleged
- dates of the incident(s) (including exact time and dates if possible)
- locations where the incident(s) took place (including name and address of the organisation, and specific wards or departments where possible)
- details of who was present (including patients, colleagues or any other witnesses)
- copies of contemporaneous notes and statements of anyone who witnessed the events alleged
- copies of medical records, MAR charts, prescriptions, which should be provided with the informed consent of the patients concerned if possible, or a clear indication as to why this has not been possible
- local policies
- details or documentary records of any admissions made by the nurse or midwife
- details of other sources of evidence in support of the allegation, where the evidence that can be provided by the referrer is limited.

If the employer hasn't finished their investigation

If a member of the public makes us aware of the concerns before an employer does, we will speak to them, ask them to tell us what happened, make sure we understand the detail, and use this when we talk to the employer about their ongoing investigation.

Generally, we would not refer the case to our investigations team for a full investigation if the employer has not finished theirs yet.

This is because the employer may not yet have found all the potential evidence or the evidence they have found may not yet be in a form that we need in order to make a confident judgement about the case.

However, we will always assess the seriousness of what appears to have happened to decide whether we need to take action while an employer is carrying out their investigation. For example, we would refer the case for a full

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investigation if the risk is not being effectively managed by an employer.

We'd also carry out our own investigation if the nurse or midwife presents such an imminent risk to patients that an interim order may be needed to restrict or suspend their practice.

If we do not need to apply for an interim order, we will usually tell whoever first raised the concerns that we do not intend to investigate yet until the employer has finished their investigation. We'll then ask the employer to make a new referral to us, if they need to, when they finish their investigation.

Where an organisation employing a nurse or midwife is aware of other investigations, such as criminal investigations by the police, these kinds of considerations won't usually be relevant.

We very strongly encourage employers to engage with us. We aim to work with senior employer stakeholders to improve awareness about our referrals process. Our Employer Link Service¹ provides advice for employers on making referrals in a way which best allows us to investigate cases promptly and effectively. Employers who need guidance on referrals should get in touch with the team using the details below.

¹ Employer Link Service can be contacted on employerlinkservice@nmc-uk.org and the advice line is (020) 7462 8850.

Stage four: Check for evidence of remediation

Reference: SCR-1d Last Updated: 28/07/2017

Sometimes we receive information about the nurse or midwife's current practice which indicates that steps have been taken to alleviate any concerns about their fitness to practise concerns since the incidents which led to the referral.

Where we have decided that a referral raises issues which are so serious that they call into question the fitness to practise of the nurse or midwife, the referral meets our formal requirements, and there is a real prospect of obtaining credible evidence, we will gather information to determine whether the nurse or midwife has taken appropriate steps to mitigate the risks presented by the case.

If the nurse or midwife has professionally reflected on the issues raised in the case, and there is evidence of relevant retraining or learning, we may decide that they no longer present any risk to patients or members of the public. In all cases, we will also need to assess whether the nature of the past events is so serious that the Fitness to Practise Committee may need to take action against the nurse or midwife's registration to promote and maintain public confidence in nurses and midwives generally, or to promote and maintain proper professional standards and conduct. If we consider that the steps the nurse or midwife has taken satisfy us that there is no longer any risk to public protection, and the past incidents were not so serious that a public hearing may be needed to consider the most restrictive sanctions for reasons of public confidence or proper professional standards and conduct, we will not need to refer the case for further investigation.

Cases not referred for further investigation

Reference: SCR-1e Last Updated: 20/03/2019

Our initial consideration of allegations will often mean we do not refer a case for a full investigation. This could be where the matters included in the referral do not amount to an allegation of impaired fitness to practise, it is not possible to identify an individual nurse or midwife, or it is not possible to obtain credible evidence in support of the allegation. We will consider, where appropriate, the use of our powers to require a person to provide us with information.¹ Before we make this decision, we will make sure that we have obtained sufficient material to enable us to understand the full seriousness of the allegation.

If we decide that the referral is serious enough to be considered as an allegation of impaired fitness to practise, we will take the steps necessary to identify whether there are possible sources of credible evidence. If there are no sources of credible evidence available we will not refer the case for a full investigation.

A decision by us that a case does not require further investigation is a decision to take no further action at that time. If we receive valid concerns about our decision we will consider these concerns and whether as a result we need to reconsider our decision.

Where new information emerges about a case that we have not referred for investigation, we will review the new information and consider, together with any material that we have retained, whether our assessment of the seriousness of the case or of the availability of credible evidence has changed. This will inform our decision as to whether it is necessary for us to investigate further.

When we review our decision, we take into account all relevant factors. This may include:

- whether the decision or part of the decision was wrong. A decision may be wrong because we did not apply our threshold test correctly, we did not follow the correct process, or we did not properly consider all concerns raised
- the amount of time that has passed since the original decision not to investigate was taken, as the passage of time could affect the strength of the evidence.

¹ Nursing and Midwifery Order 2001, article 25(1). Our powers of investigation do not include powers of entry, search, confiscation, or other investigative methods which are reserved for the police or other prosecuting bodies.

Determining the regulatory concern

Reference: SCR-2 Last Updated: 28/07/2017

If our [screening decision](#) is to refer an allegation about a nurse or midwife's fitness to practise to the case examiners, we will clearly identify and articulate the issues that concern us as a regulator. We call these regulatory concerns. A regulatory concern allows us to focus on what it is about the nurse or midwife's practice or conduct which appears to be a source of risk to patients, could affect the public's confidence in nurses and midwives generally, or might require us to take action to uphold standards.

We should always be able to express the regulatory concern about a nurse or midwife's practice in clear terms at any stage in the life of a case. This allows the nurse or midwife to understand why we say there is an issue with their practice that is serious enough to justify us a) investigating it and b) possibly restricting their right to practise or imposing other outcomes against their registration.

We review the regulatory concern in every case on an ongoing basis. It will always be drafted in the right level of detail for the stage of our process the case has reached. The level of detail is likely to increase as we gather more information and the case progresses through our investigation towards consideration by case examiners.

Explaining how and why a nurse or midwife presents a regulatory concern

Reference: SCR-2a Last Updated: 12/10/2018

In this guide

- Introduction
- Identifying what causes us a regulatory concern
- Analysing evidence of regulatory concerns
- Regulatory concerns about motivation or intent
- Statements of regulatory concern

Introduction

As we explain [earlier in this section](#), we use 'regulatory concerns' to identify and explain what it is about a nurse or midwife's conduct or practice that concerns us as a regulator. Because we may only have limited information when we are screening a case, or in the early part of our investigation, in those initial stages we usually explain regulatory concerns in fairly broad terms.

For example, if a nurse or midwife made a number of different kinds of dosing errors on different days, in the early stages of our fitness to practise process we would say our regulatory concern is that the nurse or midwife is unable to administer medication safely. We usually explain the concerns in more detail as we gather more information about what happened and how it could have put patients, members of the public, or public confidence in nurses and midwives at risk. Cases can be made up of more than one regulatory concern, and this can sometimes include concerns about the nurse or midwife's motivation, or reasons for doing or not doing something.

As the case passes through the further stages of our investigations process and is ready to be considered by case examiners, we prepare a formal statement of regulatory concern. This explains our concerns about the nurse or midwife's practice in more than detail than we will have given them when we were screening the case.

Identifying what causes us a regulatory concern

A regulatory concern will usually focus on one incident, or one series of closely related incidents. Often, problems in the nurse or midwife's practice that might seem quite separate from each other can actually be explained as one concern. For example, if the nurse who made the series of dosing errors also failed to observe patients who needed to be supervised when taking their medication, and didn't keep proper records of what medicines had and hadn't been administered, there is still likely to be one regulatory concern about whether the nurse can safely manage how they administer medicines.

An allegation about a nurse or midwife's overall fitness to practise can be made up of more than one regulatory concern. So one fitness to practise allegation could, for example, be based on three regulatory concerns: one about poor record-keeping, a second about neglecting patients, and a third concern about dishonesty based on false expense claims. If we uncover new and separate regulatory concerns as we are investigating a case, we will tell the nurse or midwife about this, and ask them to respond if they wish to. The latest we do this will be when we send them the information we've gathered at the end of the investigation.

Analysing evidence of regulatory concerns

Concerns about nurses and midwives need to be based on evidence. The way we describe the regulatory concern should always be informed by what the evidence we have tells us about possible risks to patients, or to the public's trust in nurses and midwives.

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For example, if a nurse or midwife is alleged to have been sleeping on duty, we wouldn't simply assume doing this will automatically put patients at risk, or undermine public trust, and just describe the regulatory concern as 'sleeping on duty'.

Rather, to properly consider and explain what regulatory concern the nurse or midwife presents, and what decision or action we need to take to protect the public in any particular case, we will need to carefully review the evidence and what it says about:

- what happened
- the particular setting where the incident occurred
- whether it was an isolated incident
- whether it was a conscious decision or an accident
- whether the nurse or midwife failed in their duty
- whether any background context factors influenced what happened
- whether there was a risk of patients or service users being harmed
- whether records were falsified or the nurse or midwife tried to cover up what happened

Each of these things will affect whether there is a regulatory concern about a nurse or midwife's practice, whether there may actually be more than one concern, and how we explain or describe what causes us concern.

Regulatory concerns about motivation or intent

Sometimes, the reason why the nurse or midwife did or failed to do something might itself be a regulatory concern, because it could suggest a further risk to patients, or to the public's trust in nurses and midwives, over and above the risks the conduct itself involves.

A nurse or midwife who personally contacts a patient in their care will usually present a regulatory concern, because doing so will probably mean a breach of professional boundaries. However, if the nurse or midwife tried to contact the patient because they wanted to pursue a sexual relationship with them, we would need to address this kind of motivation as a separate regulatory concern in itself.

We need a clear foundation to suggest concerns about a nurse or midwife's motives. For example, if the nurse who made the series of medication administration errors also signed the records before they began the medication round, we would need clear evidence that they had a dishonest reason for doing this before we accused them of acting dishonestly. Otherwise the concern would really still be about the management of medicines administration.

In contrast, if a midwife administered a controlled drug without anyone to act as a second checker, and later asked another midwife to sign to say that they had checked the drugs, there would be two concerns. One about the failing in administering controlled drugs, and a second, separate concern about the dishonest attempt to cover up the failing. Unlike the pre-signing of records, there is no realistic possibility of an innocent explanation for this.

Statements of regulatory concern

At the end of our investigation we will produce a statement of regulatory concern. This is a concise explanation of what we say has happened in a particular case. The statement of regulatory concern won't necessarily need to be broken down into specific episodes on specific individual dates, but it should explain what happened, and over how long.

It's important that the nurse or midwife is able to understand what we say happened, and why we say it means we may need to take regulatory action in their practice. The nurse or midwife needs to be able to tell us whether or not they accept that our concerns are well founded. Case examiners need enough detail for to make a clear and well reasoned decision about whether the nurse or midwife has a [case to answer](#), and also whether they should use their [powers to dispose of cases](#) by recommending [undertakings](#), issuing [warnings](#), or giving [advice](#).

During the investigation we sometimes receive new information which forms the basis of a further area of regulatory concern, separate from those previously identified at the screening stage. When this happens we will tell the nurse or midwife and invite them to respond.

Regulatory concerns in health cases

Reference: SCR-2b Last Updated: 28/07/2017

In cases where the concern about the nurse or midwife's practice involves their [physical or mental health](#), how we express the regulatory concern will depend on how their health condition has presented a risk to patients. It is important that we are able to provide detail of why we say the health condition is a source of concern, by referring to specific examples of risk. We will not leave the fact that the nurse or midwife has a health condition to speak for itself. Where, for example, the medical evidence makes clear that particular incidents or clinical concerns happened because the nurse or midwife has depression, making these incidents part of our regulatory concern shows the nurse or midwife why we say their depression could be a risk to patients.

For this reason, we will clearly set out any examples of the nurse or midwife having done something which put patients at risk of harm. This will be the case even where it would be possible to characterise the incidents as misconduct, if the medical evidence suggests that there is a link between what the nurse or midwife did, and the health condition they have.

Where there is sound medical evidence that the incidents would not have happened if the nurse or midwife did not have the health condition, our regulatory concern is about the way in which the health condition causes risks, rather than about the nurse or midwife's personal culpability.

Where there is no evidence of a link between what the nurse or midwife did and the health condition they have, there would be two different regulatory concerns based on two different factual backgrounds.

Cases that may involve incorrect or fraudulent entry

Reference: SCR-3 Last Updated: 12/10/2018

In this guide

- How we decide whether an allegation is about a register entry
- When we refer fraudulent or incorrect entry cases to the Investigating committee

How we decide whether an allegation is about a register entry

We sometimes receive allegations that could either be described as:

- allegations about a nurse or midwife's fitness to practise, or
- allegations about whether their entry on the register is fraudulent or incorrect.

An example if an allegation that a nurse or midwife gave us false information as part of revalidation, this could equally be misconduct that affects their fitness to practise, or grounds to investigate whether their entry on our register is fraudulent.

When this situation arises we usually prioritise the possible allegation of incorrect or fraudulent entry.

This is because we should investigate whether or not a person is entitled to practise as a nurse or midwife at all **before** we look at whether or not their fitness to practise may be impaired. It's very important for public protection that members of the public can trust the information about who is listed as a nurse or midwife on our register.

When we refer fraudulent or incorrect entry cases to the Investigating committee

Once we have investigated whether a nurse or midwife's entry on the register is fraudulent or whether it was made incorrectly, we will refer the case to the Investigating Committee.

The Investigating Committee makes a final decision on whether or not the material we gathered shows there is evidence to support an allegation of incorrect or fraudulent entry.

In making this decision we consider whether any of the information submitted, or which the Registrar took account of as part of the application process, appears to be:

- deliberately misleading
- otherwise wrong or inaccurate.

We also assess whether it appears that the entry on the register was made by mistake.

In some circumstances, we may decide not to refer an allegation to the Investigating Committee.

We are most likely to do this if:

- there is no suggestion that an entry was gained through fraud
- the error or inaccuracy in the application was trivial or unimportant
- the error or inaccuracy has since been corrected
- we have subsequently entered the nurse or midwife on the register based on correct information
- it is unlikely that the Investigating Committee would take any action if it were considering the allegation.