A personal experience of referral to the NMC

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Abstract
Taylor-Lamb AJ (2016) A personal experience of referral to the Nursing and Midwifery Council. Nursing Times; 112: online issue 1, 1-3. This narrative article reflects on the process of a real-life fitness to practise referral to the Nursing and Midwifery Council, from the moment of notification to conclusion. It explores nursing practice in line with the NMC Code and reflects on related best practice. The event that instigated the referral is presented as a case study from which a detailed reflection has been developed. This is a situation that could affect any registered nurse or midwife, at any time: both where there has been misconduct and where there has not. Key features have been identified to help emphasise their importance to nursing practice, to encourage practitioners to revisit and reflect on their own practice.

The process of being investigated by the Nursing and Midwifery Council is like being squashed into a tiny ball. It is one of, if not the most demoralising experiences of my life. One moment I was a confident practitioner, at the top of my specialty and looked up to by many colleagues, the next I felt trampled on, inadequate, fearful and guilty.

This episode of my career felt like torture. Others who have been put in this position simply for doing their job to the best of their ability will know exactly what I mean. Now I have arrived at the end of what was a dark tunnel, which resulted in “no case to answer”, I feel that I can plunge into my new role as a lecturer and be the confident professional I was 12 months ago.

The referral
I am a university lecturer, with a career history of nursing in the army, as well as in orthopaedics, gynaecology, general practice and sexual health. At the time of the incident for which I was referred to the NMC, I was a specialist community public health nurse (SCPHN) and clinical practice teacher (CPT). My role as a school nurse involved a significant element of safeguarding.

I was referred to the NMC by the parents of a young patient in October 2014. The three-page referral document raised many issues, some of which were not pertinent to me or my practice. In short, the allegations were that I interviewed their child without their knowledge or consent, and that later I referred the child to social care, again without informing the parents that I had done so. The referral described me as “vindictive” and claimed that I “launched a vicious attack”.

Investigation process
It is true that I had met with the child and made a referral to social care without parental consent. However, I believed this to be a safeguarding issue, and in such situation it may not be safe to make parents aware of some early decisions, especially in cases where there is a suspicion of fabricated/induced illness (HM Government, 2008).

5 key points

1. Referral to the Nursing and Midwifery Council for fitness to practise is a traumatic experience
2. Any nurse or midwife may face a referral, even if every care has been taken to comply with the NMC Code
3. Sometimes it can be difficult to know how to apply aspects of the Code
4. It is not always possible or appropriate to gain informed consent
5. Good record keeping is a vital defence in fitness-to-practise referrals

In this article...

- An experience of a fitness to practise referral
- Case study of the situation leading to referral
- Reflections on what was learnt
The circumstances of this event were centred on Christopher*, a seven-year-old pupil at one of the schools I worked in. My colleagues and I had experienced serious concerns about his welfare for many months due to suspicions of fabricated illness.

Our concerns related not only to Christopher’s physical health. There were also concerns that his diagnoses for a range of syndromes, diseases and illnesses were being used to confine his everyday school life, for whatever motive. Evidence to suggest and support these concerns was mainly through observation – physical and verbal – by school staff.

I had at least two safeguarding supervision sessions with my allocated safeguarding specialist. During these it was noted that, despite Christopher being the subject of concern to both education and health for some time, the “voice of the child” had not been captured. This has in recent years become an integral part of the safeguarding/assessment process (HM Government, 2015; The Children Act 2004).

I discussed this issue and its associated problems at length during supervision. These problems related to the complex nature of suspicions of induced or fabricated illness. Research suggesting that the dangers of informing parents of such suspicions (HM Government, 2008), together with the fact that the parents’ relationships with the school nursing and education services were fractured, influenced my decision to see Christopher without informing his parents.

Following supervision and much reflection, I decided to see Christopher without a formal appointment, when I was next in his school. During the consultation, I asked no direct closed questions, and used no medical terminology. As I remember, and as recorded in his community health records, Christopher talked about school, what he liked to do at break time and his friends. He also said that he did not enjoy attending all the health appointments he had, and that he was seeing the doctor that morning for an ulcer/cold sore.

We may have chatted for 5–10 minutes. My purpose for this meeting was to gain a little insight into Christopher’s wellbeing and how he presented as a seven-year-old boy. I had neither any expectation that he might disclose any information of a sinister kind, nor did I have a motive to entice him to do so.

What I saw before me was a happy, smiley little boy who was clean and tidily presented, and engaged well. I knew that Christopher was my first priority. This, taken together with research and thus evidence-based rationale, led to my decision not to contact his parents (HM Government, 2015). My knowledge of children at risk, gained from reading serious case reviews and executive summaries (Laming, 2009), gave me the motivation and sense to see this child in line with policy and procedure.

Over subsequent weeks, it became clear that Christopher’s mother was unhappy about me seeing her son.

About three months after my meeting with him, and more incidents that raised concerns among education and health professionals, it was decided to refer him to social care services. I undertook the referral, and two months later his parents referred me to the NMC.

At the time of the incident that led to the referral I was a member of the Royal College of Nursing, so I was allocated a legal representative, which was an enormous relief. From that time, all liaising with the NMC was done through my solicitor, who asked me to write a reflective piece on the incident, and how I could learn from it. He also requested contacts for referees, my CV, and a list of all training I had done in the preceding 12 months.

The initial NMC screening process took more than three weeks. I then received a letter informing me that the case had been transferred to the investigation team. It was not until four months after my first NMC telephone contact that the investigation officer wrote to me explaining that the process could last from four to six months. It is difficult to describe what it is like to go to work every day knowing that in the very near future, everything could collapse and be taken from you. However, it is important to believe in the fairness of the process. I had to have faith in the NMC and its duty to investigate. I suppose I thought that the more rigorously the referral was investigated, the better the outcome would be, and that truth and honesty would prevail. At no point did I feel unable to go to work; I was determined to maintain my resolve.

Despite this, I did have two moments where I felt overwhelmed and unable to continue. However, my solicitor took a supportive stance and advised me to turn my frustrations into something constructive, using my feelings to explain why I had made the decisions I had.

In mid-August, the NMC informed me the investigation officer had concluded that I had no case to answer. However, the case had to be presented to the case examiners, which can take up to two months. I was elated at the outcome of the investigation, but frustrated that I had yet more waiting to endure before being officially exonerated. The patience of those referred to the NMC is truly tested to the limit.

On 2 October, almost a year after I was informed of my referral, I finally received a call from my solicitor; the case examiners had agreed with the investigation officer: there was no case to answer. My decisions did not demonstrate that my fitness to practise was impaired.

Reflections on the Code

The referral raised issues pertaining to a number of sections in the Code (NMC, 2015). Below are my reflections on my practice relating to these.

Consent

More often than not, nursing practice involves gaining verbal/implied consent before undertaking procedures, and documenting that this has been obtained. There must therefore be flexibility in this, dependent on the intended action, with guidance from local policy.

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**BOX1. CASE STUDY: THE REFERRAL INCIDENT**

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obtained. But be warned: both local and national policy must be adhered to, and supervision sought. Should I face such a situation again, I would make every effort to gain consent from the parents before seeing the child. At the time, I was aware of how difficult this would be and even, on reflection, I struggle to understand what the right action would have been.

Record keeping
A vital aspect of healthcare is for documentation to be completed as soon as possible following an episode of care. This is a practitioner’s only dependable form of evidence that care was delivered a certain way – and thus, crucially, defence if a complaint is made.

There was a plethora of short communications to many professionals in relation to this case, and in such situations it can be easy to miss inputting every contact that takes place. However, when faced with an NMC fitness-to-practise allegation, good record keeping becomes vital.

Supervision
Clinical supervision can be imperative to development, and supportive for difficult decision making. However, while in some specialties supervision is mandatory and supported well by management, in others it may not be so easy. If a formal structure is not in place, try to take time to liaise with colleagues and discuss more challenging scenarios or cases. Supervision can help to gain a wider perspective and improve clinical confidence (Bond and Holland, 2010).

I took every opportunity I could to discuss this case with my safeguarding specialist, between prearranged supervisions in ad hoc telephone calls. Although this did not prevent the referral, due to local trust safeguarding policy it was imperative that I was able to demonstrate that supervision had been undertaken.

Multidisciplinary working and communication
It is impossible to work effectively with allied professionals without effective communication, and this feature of nursing connects well with record keeping. Whether information sharing with a colleague, delegating a task or communicating with a patient, the importance of team working applies throughout.

On occasion, due to awkward relationships and swayed decision making, we can agree to actions that may not be an appropriate choice. Sometimes it takes courage to do the “right thing” (Broadhurst et al, 2010). In this situation, difficulties between myself and the parents heavily influenced my ability to communicate with them effectively; it is possible that this impaired my decision to seek consent before meeting with the child.

Conclusion
The entire NMC investigation and process took over 10 months, and 2015 was clouded by the fear of losing everything I had worked for over the previous 14 years. Not only was it difficult to find solace, but it prevented me finding any happiness or fulfillment in life. However, now this episode is over, I feel stronger, and able to move on.

The final report from the case examiners stated: “...there is no evidence to suggest that actions were inappropriate or vindictive.” It was important to me that this was defined: I am a good person. To have this challenged was the hardest accusation of all.

This article has raised important issues to consider and reflect upon when thinking about your own practice. As a regulated health professional, you never really know when a situation such as this could arise, no matter how compassionate and competent you may be. Today, I have a completely different role that does not include clinical work, but I would like to use my experience in a positive way to help educate our future nurses.

References

For more on this topic go online...
What to do if you are referred to the Nursing and Midwifery Council
bit.ly/NMCReferral

**Try to take time to liaise with colleagues and discuss challenging scenarios or cases**