ADAM STRAIN

Date of birth: 4th August, 1991

Report into the nursing care given at Royal Belfast Hospital for Sick Children, November 1995

Report prepared by: Sally G. Ramsay

Report prepared for: The Inquiry into Hyponatraemia-Related Deaths, Northern Ireland.

10th February, 2011

Report of: Sally Ramsay
Specialist field: Children's Nursing
Child: Adam Strain
On behalf of: The Inquiry into Hyponatraemia-Related Deaths

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1.0 INTRODUCTION

1.1 The writer

I am Sally Grace Ramsay. I am registered with the Nursing and Midwifery Council (NMC) as both an adult and a children's nurse. I have managed children's services in both the NHS and independent sectors. My specialist fields are the nursing care of sick children, clinical governance and professional nursing issues. I undertook training in renal nursing in 1974 and subsequently managed children's renal services at both Guy's and Great Ormond Street Hospitals. Full details of my qualifications and experience entitling me to give expert opinion are in Appendix 1.0.

1.2 Summary of the case

Adam Strain had chronic renal failure, although he continued to pass urine. Since 1994 he had been treated at home with peritoneal dialysis. He was fed through a tube into his stomach (gastrostomy[1]).

On 26th November 1995, Adam was admitted to Musgrave Ward at the Royal Belfast Hospital for Sick Children (RBHSC) in order to undergo a kidney transplant, planned for the following morning.

During the night of 26th November, Adam underwent peritoneal dialysis and was given fluids both intravenously and through the gastrostomy tube.

[1] A tube inserted through the abdomen into the stomach

At 06.55 on 27th November Adam was transferred to the operating theatre where he underwent a kidney transplant. At the end of the operation Adam did not regain consciousness. He was transferred to the Paediatric Intensive Care Unit (PICU) where he subsequently died. His death has been attributed to swelling of his brain (cerebral oedema) as the result of low sodium levels in his blood (dilutional hyponatraemia).

1.3 Summary of my conclusions

I have concluded the following with regard to the nursing care given to Adam.

- The record-keeping in relation to fluid and nutritional management and dialysis was inadequate.

- The intravenous fluids given on Musgrave Ward were not given at the rate prescribed.

- Adam's normal medicines were not prescribed, or if prescribed, were not given.

- There were omissions in pre-operative observations of height, weight, blood pressure and temperature.

- The operating theatre nursing was appropriate and despite the absence of a formal care plan, the records are of an acceptable standard.

- Records in relation to the information, advice and support given to Mrs. Slavin were inadequate.

1.4 Parties involved

- The Inquiry into hyponatraemia-related deaths in Northern Ireland
- Royal Belfast Hospital for Sick Children
- Mrs. Slavin, mother of Adam Strain

2.0 THE ISSUES ADDRESSED

I have been asked to comment on the following:

- The adequacy of the record-keeping of Adam's fluid and nutritional management and his dialysis.

- The nursing elements of the transplant surgery and the adequacy of the records maintained

- The quality of the information given to Adam's family

- The specific matters identified by the Inquiry's Expert Advisors (Appendix 1.)

3.0 MY INVESTIGATION OF THE FACTS

Adam Strain was born on 4th August, 1991. As the result of problems with his kidneys and urinary tract he underwent several operations and required numerous admissions to hospital. When his kidneys stopped working effectively in 1994, treatment with

peritoneal dialysis was started, using a PacX machine[2]. This procedure required a catheter to be inserted into Adam's abdomen. A nursing care plan, completed at the time, shows a nursing assessment (057-023-037, 057-023-038) and documentation of problems, goals and nursing actions (057-024-039). The latter includes the pre-operative care required before the tube was inserted "*Fast from 12mn, Consent form, Bath, I.D bracelet, Wt., All procedures explained to mother.*"

Adam's mother was subsequently trained to use the PacX machine at home. The nursing records do not include details of the dialysis prescription. However, an entry in the medical record (058-035-143) dated 9/11/95 states:

> *"Dialysis – Dry weight 20Kg*
> *750mls x 15 cycles ½ hr dwell*
> *13 hrs"*

Adam had all his feeds through the gastrostomy tube. Entries in the medical record dated 9/11/95 shows Adams feeds "*gastrostomy – 3x200 bolus*"[3] and "*1500ml O/N*"[4]

In October, 1995, he underwent operations for insertion of a gastrostomy button[5] and undescended testes. (058-035-130).

At approximately 21.00 hrs on 26th November, 1995, Adam was admitted to Musgrave Ward at the Royal Belfast Hospital for Sick Children as a kidney had become available

[2] An electronic machine that performed dialysis to a pre-set programme.
[3] Three feeds of 200mls
[4] 1500mls overnight
[5] A type of gastrostomy tube.

for transplantation. There are no records showing Adam's general state of health at this time but in his statement (058-035-130) Dr. Savage described him as "*A well-nourished, well grown boy*".

Information recorded on the nursing admission sheet (057-013-017) lists Adam's "*Current medication*" as:

> "*Sod bic*[6]
>
> *Keflex*
>
> *Ketovite*
>
> *One alpha*
>
> *Cal Carbonate*
>
> *Ferrosimil*"

An entry in the medical records (058-035-131), under the heading "**Medicines**", shows "*as in past*". However, there are no records to confirm that these medicines were either prescribed or given. In the section "**Drugs – once only prescriptions**" (057-021-033) there are entries dated 26th November prescribing vancomycin and gentamycin "*via PD cannula*". but the section "**given by**" is blank. Paracetamol was prescribed on 27th November (057-021-034) and given at "*2AM*" (057-022-035).

Single recordings of temperature, pulse, respiratory rate, blood pressure and weight are shown on two charts (057-011-015, 057-011-016). These are also documented on the admission sheet (057-013-018):

[6] Sodium bicarbonate

Temperature – 36.7 Pulse – 97 Blood pressure – 108/56 Weight – 20.2 Kg

An unlabelled sheet (057-013-018) lists elements against which Adam's nursing needs were assessed. Under the heading **"Eating and drinking"** the entry shows "*T[7] feeds – bolus during the day and continuous overnight*". Under **"Eliminating"** the entry shows "*wears a nappy. Passes large amounts of urine. Peritoneal dialysis overnight."* Adam is noted as being "*very active and chatty*" (057-013-018).

An entry on the "**Evaluation sheet**" timed at 10pm, states "*admitted for ? renal transplant. Clear fluids via gastrostomy @ 180mls/hr. I.V. fluids @ 20mls/hr. Normal PacX until 6am*" (057-014-019)

A later entry timed at 1.30am states "*IV cannula tissued[8]. Dr. O'Neill informed. Gastrostomy fluid ↑ 200mls/hr. Re-insertion of cannula at 5am*". In her statement (093-007-024) Staff Nurse Murphy, who was on duty that night (093-007-023, 093-007-024) recalls that Dr.O'Neill had difficulty reinserting the cannula and as a result Adam went to the operating theatre "*without IV access*".

Dr. Cartmill recorded in the medical records "*To have I.V. fluids @ 75mls hr (maintenance)*" (058-035-144) and prescribed this twice on the **Intravenous Fluid Prescription** (057-010-014) as "*500mls, 0.18% NaCl 4% Dextrose*" at a rate of "*75mls*" per hour. The columns showing the time the infusions started or finished or by whom they were initiated, are blank.

[7] Abbreviation for tube (gastrostomy) feeds
[8] Intravenous infusion has stopped working as the result of leakage of fluid into the surrounding tissues

A **Fluid Balance and I.V. Prescription Sheet** (057-010-013) has entries showing that at 23.00 hrs an infusion of "*5/N @ 20mls/hr*" was started. At 01.30 it had "*tissued*" with "*18mls*" having been given. Further entries in the "**Oral**" columns show "*clear fluids @180mls/hr*". At 0200 the entry states "*↑ 200 mls/hr.*" The total amount given during the night is shown as "*952*".

There is no indication of the type of clear fluid given orally, however, Dr. Savage, in an untimed entry in the medical record, dated 27/11/95 (058-035-133) wrote "*PD fluid O/N*[9] *./c van & gent.....on dioralyte o/n rather than Nutrazan*". Later in his statement (011-015-109) recalls the clear fluid was "*N/5 Normal Saline dextrose*", but there are no corresponding nursing records to confirm this. Adam passed urine at 01.30.

The **Paediatric Peritoneal Dialysis Prescription** (057-015-021) is dated 27/11/95. There are no nursing records regarding the peritoneal dialysis for the 26th and 27th November, 1995 and no entries concerning the dialysis in the medical records for that date. (058- 035-143, 058-035-144).

There are no records to indicate that after the initial admission assessment, any further observations of temperature, pulse, blood pressure or weight were made prior to the transplant operation. An attempt was made to capture a urine sample and "*Bag in situ*" is written on the admission chart (057-013-18). There are no entries to confirm the specimen was collected.

[9] Abbr. for overnight

There is no nursing care plan detailing any nursing problems, goals and actions while on Musgrave ward. From the Intensive Care Unit care plan it appears Adam's mother was expecting him to be admitted there after the transplant (058-038-156)

On the admission sheet (057-013-017) the "**Parents/perception of admission**" section shows "*Deborah understands*", but there are no further entries in relation to Mrs. Slavin.

A **Care Plan for Patients Undergoing Surgery** (057-026-043, 057-026-044, 045,046), although not specific to Adam's surgery, shows sections for "*Pre-surgery assessment by theatre staff, patient identification checklist, potential problems, aim of care, nursing actions, evaluation".* There are no similar entries in the care plan for 27th November.

An "*Admission protocol*, dated 1990 and headed "**Renal transplantation in small children**" lists the following pre-operative requirements:
"*Note – residual renal function and urine output"*
"Examination – State of nutrition and hydration
Blood pressure
Height and weight"

At 06.55 on 27th November, Adam arrived in the operating theatre. (094-006-021). There is no theatre care plan.

The first blood pressure recording in the operating theatre was recorded electronically at 07.30 and the graph, (058-008-023) shows a reading of 98/40 approx. There is no record to indicate that a urinary catheter was inserted in the operating theatre.

There are records of **Blood Loss** (058-007-021) and **Swab Count** (058-007-020) during the transplant. The latter has an illegible signature and records S/N Popplestone as the Scrubbed Nurse and P. Conway as the person who performed the pre-operative swab count. From the statements (093-009-028, 093-013-042, 093-012-039) it appears Staff Nurse Conway was on duty during the night of 26/27th November and Staff Nurses Matthewson (circulating nurse[10]) and Popplestone (scrubbed nurse) were present during the operation.

Following the transplant procedure Adam did not regain consciousness. There are no nursing records from Musgrave ward to show when Mrs. Slavin was made aware of the problems. Dr. Mary O'Connor, Consultant Paediatrician has stated "*It is my normal practice to relay to parents information from theatre informing them as to the stage of the operation and generally how matters are progressing*" (093-020-059).

Adam was transferred to the Paediatric Intensive Care Unit (PICU). In the **Relative Counselling Record** (058-038-180) Staff Nurse Beattie has recorded details of the interviews held between Dr. Savage, Dr. Taylor and Adam's mother.

[10] Can also be called a "runner"

Adam subsequently died. His death has been attributed to swelling of his brain (cerebral oedema) as the result of a reduction in the sodium level in his blood (dilutional hyponatraemia).

4.0 MY OPINION

4.1 Background information

At the time of his admission for a kidney transplant, Adam was being successfully cared for at home by his mother, Mrs. Slavin. He was not acutely ill. During his stay on Musgrave Ward he required continuation of his usual dialysis, feeds and medicines, with any adjustments in preparation for the transplant. His stay on Musgrave Ward was intended to be short, as post-operatively he would transfer to the Paediatric Intensive Care Unit.

Standards for Records and Record-Keeping were published by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, in April 1993[11]. The document described the purpose of nursing records as follows:

- To provide accurate, current, comprehensive and concise information concerning the condition and care of the patient and associated observations;

- To provide a record of any problems that arise and the action taken in response to them

[11] Former regulatory body for nurses.

- To provide evidence of care required, intervention by professional practitioners and patient or client responses;

- To include a record of any factors (physical, psychological or social) that appear to affect the patient;

- To record the chronology of events and the reasons for any decisions made;

- To support standard setting, quality assessment and audit

- To provide a baseline record against which improvement or deterioration may be judged.

It is my view that nursing records, at the time, usually included the following elements:

- **An assessment** – recording background information on the child and family
- **A plan of care** – showing problems and potential problems, goals of care and the required nursing interventions. Pre-printed care plans were often used to assist nurses in planning care.
- **An evaluation** – a record of the outcome of each nursing intervention, and any changes to the child's condition.

Some nursing records also included a communication sheet where information shared with other professionals and discussions with parents could be recorded.

More recently, Glasper and Richardson (2006), in describing care planning, wrote "*the plan of care is a communication tool and makes it clear to all who will be doing what, when and how. It can be as simple as a checklist or as complex as a step by step statement of a procedure with timed goals and expected outcomes.*"

In reality, a balance must be made between delivering care and maintaining a comprehensive record. To facilitate improvements in record-keeping, checklists and pre-printed care plans have been used. These make the nursing actions clear and save time in writing down commonly know elements of care. Some records are now computerized.

With regard to recording any medicines given, the document **Standards for the Administration of Medicines** (UKCC, 1992) stated nurses will "*make clear, accurate and contemporaneous records of all medicines administered.*" This meant that nurses, and sometimes the person who had checked the medicine, signed to say it had been given. Prescription sheets included sections for this.

4.2 Care plan – Musgrave Ward

The nursing records include an initial assessment, undertaken when Adam was admitted to Musgrave Ward. (057-013-017). Information includes the need for tube feeds and peritoneal dialysis. There is no detailed information regarding the volumes of feeds and fluids or the dialysis cycles. This, in my opinion, is acceptable as the requirements can change and practitioners should always refer to the current prescription before initiating any therapy.

The absence of a plan of care suggests that either one was not written or that it has been lost. In my opinion, it was known that Adam would only be on the ward for a short period of time and would go to PICU afterwards. This, in all likelihood, reduced the need for a lengthy and detailed care plan and consequently, a care plan was not written. It also appears that pre-operative and transplant checklists listing observations, fasting time, bath, consent and medicines given, were not used.

In my opinion, some elements of care required more detailed documentation. These included the plan for gastrostomy feeds, medicines given, peritoneal dialysis and care of the intravenous infusion. I have, therefore, concluded that the record-keeping fell below the expected standard.

4.3 Intravenous therapy

When intravenous therapy was prescribed it was usual practice for the nurse to sign that it had been initiated. The **Intravenous Fluid Prescription Chart** (057-010-014) has columns for the start and finish times and the initials of the person erecting the infusion to be recorded. Latterly, the batch number of the infusion bag has been recorded in case of an adverse event.

Dr. Cartmill prescribed Intravenous therapy of 0.18% NaCl (sodium chloride) and 4% Dextrose at a rate of 75mls per hour (057-024-039). The time the prescription was written is unknown; however Dr. Cartmill recorded her plan at 9.30pm. (058-035-144). The first recording for intravenous fluid given was made at 23.00hrs. This was for "*5/N @ 20mls/hr*". It appears that "*5N*" was an abbreviation for a solution containing 0.18%

saline and dextrose. It is likely, therefore, that the actual fluid given was that prescribed by Dr. Cartmill.

It is my opinion that 20mls hourly was the rate set when the cannula was inserted and the infusion initiated and this was not changed when the prescription was written. Consequently, it is my view that there was a failure to undertake appropriate checks of the infusion type and rate, resulting in a rate that was different to that prescribed.

4.4 Gastrostomy feeds

The intended total fluid intake is not clear in either the nursing or medical records. It appears Adam was given "*clear fluid*" feeds totalling 952mls between 01.30 and 0500 (057-010-013), although these are not recorded as bolus feeds. There are no individual hourly recordings, only what appears to be a running total. Nowhere is the type of feed recorded.

In my experience "*clear feeds*" describes various solutions that are easily absorbed. These include water and glucose (dextrose) in water which were available in commercially prepared small bottles. I am unable to recall whether Dioralyte and normal saline with added glucose were commercially available in similar bottles at this time.

In view of Adam's underlying medical condition, it is surprising that the records do not state specifically which clear fluid was given. I regard this as an omission in record-keeping. I also consider the recording of the actual feeds given to Adam was below the required standard.

4.5 Peritoneal Dialysis

Adam had been treated with peritoneal dialysis at home since 1994. My understanding is that the dialysis was effectively managed by his mother, using a PacX dialysis machine. I believe the PacX machine was specifically designed for home use. The machine could be set with a fill time (the period during which the fluid enters the abdomen), dwell time (the duration for the fluid to remain in the abdomen) and drain time (the time it took to drain out). There were alarms to indicate any deviation from the settings made. I believe there may have been an alarm log to look back at. Before a nurse could administer dialysis she needed a prescription detailing the type of fluid (dialysate), the volume for each cycle, the number of exchanges and the dwell time.

There was no prescription for Adam's dialysis on the night of 26th November although there was a prescription for Vancomycin and Gentamycin to be given through the peritoneal catheter.

Adam's condition was stable, there were apparently no changes from his usual dialysis prescription and the PacX would alarm at any deviations from the programme e.g. failure to fill or drain. Consequently, I do not think it was necessary to record details of every cycle. However, it is my opinion that the records should have included the type of dialysate used; the fill, dwell and drain times; the time treatment started and ended; the number of cycles completed; any alarms. It is my opinion that the prescription for Vancomycin and Gentamycin should have been signed (057-021-033) to confirm the medicines had been given.

As Staff Nurse Murphy completed the admission sheet and made entries in the evaluation sheet I believe she was caring for Adam and consequently had responsibility for ensuring appropriate records of his dialysis were made.

My view is that the record-keeping in respect of the dialysis fell below the required standard.

4.6 Vital sign recordings

On admission, observations of Adam's temperature, pulse, blood pressure and weight were made and recorded. No further recordings were made and it is my opinion that these observations should have been repeated on conclusion of dialysis.

Both weight and blood pressure are indicators of fluid balance and are usually checked regularly when a child is in hospital. For Adam I believe these were important observations to repeat in view of the reduced period of time he spent on dialysis. Peritonitis is a major complication of peritoneal dialysis. A change in temperature can be an indicator of infection. Therefore, a temperature recording just before surgery was, in my view, important.

Adam's height was not measured. This is a normally done on admission to hospital. It is an indicator of growth and also allows for a body surface area to be calculated. The latter is important for calculating some medicines. The need for height to be measured is clearly stated in the **Admission Protocol,** dated.

There is one recorded instance of Adam passing urine at 01.30. This was not measured. Estimating urine volume in a child in nappies can be achieved by weighing the nappy before and after use.

In my opinion, this aspect of nursing care was below the standard expected for any child due to undergo major surgery, particularly a child in chronic renal failure.

4.7 Medicines

The nursing admission information lists the medicines that Adam was given at home. As there is no prescription I have concluded they were not prescribed to be given in hospital.

The responsibility for checking a child's medicines and prescribing them rests with the admitting doctor. However, it is surprising that having recorded details of all the medicines, Staff Nurse Murphy failed to prompt either Dr. Cartmill or Dr. O'Neill to write the prescription.

4.8 Operating Theatre nursing

Staff Nurse Conway who was on duty during the night of 26th November, prepared the operating theatre in readiness for the transplant, before going home. I have concluded that two registered nurses were on duty in the operating theatre during the transplant. Staff Nurse Poppleton, as the scrubbed nurse, had responsibility for passing instruments

to the surgeon. The other, S/N Matthewson was the circulating nurse or "runner" who weighed swabs and recorded the total blood loss (058-007-021).

There is no nursing plan of care for Adam's time in the operating theatre. On previous occasions a pre-printed care plan was used. It is easier, in my view, to prepare a theatre care plan during the day when more staff are available. The pre-printed care plan lists nursing actions as "*Monitor, record and report intake and output, if necessary. Weigh swabs and record and report to anaesthetist if necessary.*" I have concluded that these were normal nursing roles. I consider the Blood Loss and Swab Count records are of an appropriate standard. As Adam was undergoing major surgery, I consider that the anaesthetist had responsibility for prescribing, administering and monitoring the intravenous fluids during the operation.

There is no record showing a urinary catheter[12] was inserted into Adam's bladder. At this time, catheterisation of boys was always performed by doctors. I note that Mr. Koffman, in his Medico-Legal Report (094-007-027) states "*A minority of patients are polyuric and the bladder may be left on free drainage in these patients. It would not be particularly important to monitor urinary output in these patients as the critical monitoring would be central venous pressure and BP (blood pressure).....*"

McGarvey et al (2000) in describing the reality of operating department nursing stated "*there are indisputably nursing actions which are in response to medical orders and treatment during anaesthesia.*" It is my opinion that the anaesthetist was responsible for

[12] A tube to drain urine into a bag.

monitoring and managing fluid balance. If he needed assistance in monitoring urinary output, a specific member of the team should have been identified to do this.

In view of Mr. Koffman's comments I do not consider that failure to monitor urinary output was an omission in nursing care.

4.9 Organisation of care

An Admission Protocol, written in 1990, was available to guide pre-operative care. However, there was no specific pre-operative checklist to guide the pre-operative nursing interventions. The **RBHSC Renal Transplant Guidelines** were updated in September 1996 and include a plan of care and a Theatre Checklist.

It is my overall impression that the care given to Adam pre-operatively lacked structure and this resulted in omissions in his care

4.10 Communication with the family

Kidney transplantation is a welcome, but worrying development for the child and family. In the hours prior to the operation Mrs. Slavin would have needed support, reassurance and clarification of information already given. The nurse should have checked her understanding of the operation, confirmed what would happen and listened to her anxieties.

Much of the information required by Adam's mother should have been imparted beforehand, in the outpatient department. However this may have taken place many months before the kidney became available. Therefore, it is likely that Mrs. Slavin needed further explanations and support at this stressful time.

Where the nurse was unable to answer a query I would have expected her to seek out someone who could. Patient care demands may have limited her ability to support and advise Mrs. Slavin.

In some hospitals a communication sheet has been used to record details of discussions with families. Indeed the PICU had a "**counselling record**". However, it can be difficult for nurses to record conversations in detail due to time constraints. Records may only give brief details of any information given to a family. At that time, written information for parents was either unavailable or, in my view, poorly written.

I believe that, other than for child protection purposes, few hospitals at the time would have had clear protocols to guide nurses in communicating with families. However, underpinning all communication was the UKKC (1992) Code of Conduct that stated "*work in an open manner with patients and their families*". However, what a nurse could say was often limited by her knowledge of the situation and by fear of saying the wrong thing.

Current practice as described by Kelsey and McEwing (2008) is to "*Record the discussion in relevant documentation*". Their rationale is that this ensures continuity of care and reduces the potential for error or conflicting information. However, guidance on

what to record is limited. As a minimum I would have expected the nursing records from Musgrave Ward to include more than "*Deborah understands*" (057-013-017).

I have concluded that once Adam had left the ward the responsibility for on-going communication with his mother about events in the operating theatre was the responsibility of medical staff. In my experience it would be usual for a parent to use the ward as a base while waiting for the child to transfer to the recovery ward or intensive care unit. This allows for a ward nurse, preferably someone known to the parent, to take them to see their child and support them in the process. When Adam left Musgrave ward, the nurses would not have had responsibility for communicating with his mother regarding events occurring in theatre, indeed Dr. O'Connor states that she was responsible for communicating with the parents during a transplant.

In her statement (011-09-026) Mrs. Slavin recalls that after initially seeing Adam in PICU, she was taken away for a cup of tea and subsequently "*not allowed*" to see him again. I believe it was common practice at the time to leave parents in a side room to wait until the child's condition stabilised. However, I would expect a nurse to have been allocated to be with the family to ensure continuing support and communication. As Mrs. Slavin's perceptions of her experience at the time are unknown to me, I am unable to comment on whether the support given was of an appropriate standard.

The intensive care unit records included a "**Relative Counselling Record**" in which Staff Nurse Beattie has recorded the conversation between Dr. Savage, Dr. Taylor and Mrs. Slavin at which she was present. This appears to be an appropriate record.

When Adam was diagnosed as brain-stem dead, it would have been normal, in my opinion, for a nurse to remain with his mother and family in order to provide on-going support and ensure effective communication. The nurse would need to establish parents' wishes regarding any religious requirements, contact other family members, give information on the process of discontinuing treatment. When treatment had been discontinued I would expect the nurse to facilitate the family in holding the child, remaining at a discreet distance while the family grieves. The nurse should also facilitate contact with the hospital's bereavement services and ensure the family has information on bereavement support services.

4.11 Operating a blood gas machine

The document **The Scope of Professional Practice** (UKCC, 1992) facilitated nurses in enhancing their skills and undertaking tasks that had previously been performed by doctors. The underpinning principles were that registered nurses must:

- Ensure they were not compromising or fragmenting existing aspects of practice.

- Always endeavour to achieve, maintain and develop knowledge and skill.

A nurse could be asked to operate a blood gas machine. However, it would have been appropriate for the nurse to refuse if he/she did not feel competent in using the machine safely. **The Code of Professional Conduct** (UKCC, 1992) confirms this by stating "*acknowledge any limitations in your knowledge and competence and decline any duties and responsibilities unless able to perform them in a safe and skilled manner*"

I think the operating theatre and PICU nurses were more likely to be competent in using a blood gas machine than nurses in Musgrave Ward.

5.0 CONCLUSION

I have concluded the following:

- The record-keeping in relation to Adam's fluid and nutritional management and his dialysis was inadequate.

- The intravenous fluids given on Musgrave Ward were not given at the rate prescribed.

- Adam's normal medicines were not prescribed, or if prescribed, were not given.

- There were omissions in pre-operative observations of height, weight, blood pressure and temperature.

- The operating theatre nursing was appropriate and despite the absence of a formal care plan, the records are of an acceptable standard.

- Any communication between nurses and Mrs. Slavin was not documented.

I believe the questions posed by the expert advisors to the panel have been answered within the body of the report.

6.0 STATEMENT OF COMPLIANCE

I understand my duty to the Court, and have complied with that duty.

7.0 STATEMENT OF TRUTH

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Signed  Date 10th Feb 2011

APPENDIX 1

ISSUES IDENTIFIED BY THE INQUIRY'S EXPERT ADVISORS

1. The recording of the peritoneal dialysis/fluid balance in relation to Adam's stay in the ward prior to theatre. Consideration to include:

    - The recording of dialysis cycles
    - Pre- and post dialysis weighing
    - Responsibility for monitoring and documenting Adam's dialysis
    - The role of the nurse in checking that medicines were prescribed

2. The information that the nurses should have been exchanging with Adam's family about the transplant immediately prior to the transplant, during it and after he left the operating theatre, during his time in PICU until he was pronounced brain-stem dead. This should include:

    - The local policy on the provision of information to parents about their children and relating to recording the information provided
    - What was and is acceptable practice in giving and recording information provided to children and their parents pre-operatively.

3. Whether at the time of Adam's transplant nurses could be asked to operate a blood gas machine in the case of:

    - A theatre or PICU nurse
    - A ward nurse

4. To comment on the lack of recording of urine output in theatre.

APPENDIX 2

DETAILS OF MY QUALIFICATIONS AND EXPERIENCE

PROFESSIONAL QUALIFICATIONS

Registered Nurse (Adult)	Nursing and Midwifery Council	1972
Registered Nurse (Child)	Nursing and Midwifery Council	1974

CURRENT EMPLOYMENT

Self-employed Children's Nursing Advisor **2003-present**

Work has included:

- Member, National Clinical Advisory Team, Review of Neonatal Services, Norfolk, Suffolk and Cambridgeshire.
- Member, Review Team, Safe and Sustainable Children's Heart Surgery in England
- Preparing standards, competence based education and training frameworks and other documents for the Royal College of Nursing.
- Preparing expert witness reports
- Reviewing nursing services in independent schools
- Nursing and Midwifery Council – Reviewer for nurse education programmes
- Implementing clinical governance in a children's service of an NHS Trust.
- Interim.
- Director of Governance, Royal Orthopaedic Hospital, Birmingham – 2 periods
- Practitioner panellist, Fitness to Practise Investigating Committee, Nursing & Midwifery Council
- Bank staff nurse, NHS Professionals

CAREER HISTORY

Portland Hospital for Women and Children **2002-2003**

Independent hospital providing maternity, neonatal and children's services

Chief Nursing Officer

Responsible for:

- Managing nursing and midwifery service.
- Implementing clinical governance strategy
- Clinical risk/complaints management
- Compliance with National Minimum Care Standards
- Nursing/midwifery development, education and training

Great Ormond Street Hospital for Children NHS Trust **1994-2002**

Director of Nursing and Family Services
Director of Nursing, Quality and Clinical Support

Responsible for:
- Standards of nursing practice, education, training and research.
- Managing clinical risk, complaints and litigation.
- Managing Professions Allied to Medicine
- Managing family support services

Hospitals for Sick Children, Special Health Authority. **1992-1994**

Director of Nursing

Guy's and Lewisham NHS Trust **1990-1992**
Clinical Services Manager – Paediatric and neonatal services.

Ealing Hospital **1988-1990**

Manager, Children's Service

Guy's Hospital **1986-1988**

Nurse Manager – paediatric and neonatal intensive care unit

Various posts at Nurse Manager, sister and staff nurse level **1972-1990**

EDUCATION

Renal nursing course, Guy's Hospital **1974**

B.A. (Hons), Social Science, 2:1, Middlesex Polytechnic **1986**

M.Sc. Nursing, King's College London **1992**

PROFESSIONAL ACTIVITIES

Member, National Co-ordinating Group on the Provision of Paediatric Intensive Care 1996-1997
United Kingdom Central Council for Nursing, Midwifery and Health Visiting Council Member 1995-2002
Member, Chief Nursing Officer's Task Force on the future nursing workforce in paediatric intensive care, 1997.
Member - the Expert Working Group on Alarms on Clinical Monitors in Response to Recommendation 11 of the Clothier Report: The Allitt Enquiry (1996)
Bond Solon expert witness training in 2002.

VOLUNTARY ACTIVITIES

World Child Cancer - Trustee	2010
CLIC Sargent – Children's Cancer Charity – Trustee	2004-2010
Chronic Granulomatous Disease Research Trust – Nursing Advisor	2009-2010

PUBLICATIONS

Ramsay S. Treading the wards again (2004), Paediatric Nursing 16(3)
Nethercott S. (1999) Child Support. Nursing Standard 13(17)
Nethercott S. (1994) The assessment and management of post-operative pain in children by RSCN's: an exploratory study. Journal of Clinical Nursing 3, 109-114
Nethercott S. (1993) A concept for all the family. Family centred care: A concept analysis. Professional Nurse 8(12), 794-797

Documents written for the Royal College of Nursing

- Restrictive physical interventions and therapeutic holding for children and young people. (2010)
- Standards for admission to and discharge from hospital (awaiting publication)
- Mental Health in Children and Young People – A toolkit for general nurses (2009)
- An Education and Training Competence Framework for Intravenous Cannulation in Children and Young People (2005), updated 2009
- An Education and Training Competence Framework for Administering Medicines Intravenously in Children and Young people. (2005), updated 2009
- An Education and Training Competence Framework for Capillary Blood Sampling in Children and Young People. (2005) updated 2009
- Managing fever in infants, children and young people (2008)
- Malnutrition: What nurses working with children need to know and do. (2006)
- Bottle feeding: A guide for nurses (2007)
- Measuring and Recording vital signs in infants, children and young people: an education and training competence framework (2007)
- Standards for assessing, measuring and recording vital signs in infants, children and young people (2007)

APPENDIX 3

DOCUMENTS I HAVE EXAMINED

CORE BUNDLE

Tab 1-Original and revised Terms of Reference
Tab2- Protocol on Experts
Tab.3 (from Inquest documents):

Depositions:

- Dr. Maurice Savage (011-015, Tab 3a)
- Mr. Patrick Keane (011-013, Tab 3b)
- Dr. Alison Armour (011-010, Tab 3c)
- Dr. John Alexander (011-012, Tab 3d)
- Dr. Robert Taylor (011-01'4, Tab 3e)

Reports:

- . Professor Peter Berry (011'-007, Tab 3f)
- . Dr. Edward Sumner (011-011, Tab 39)

Tab.4 (from Inquiry documents):
Witness Statements of:

- Dr. Maurice Savage (Tab 4a)
- Mr. Patrick Keane (Tab ab)
- Mr. Stephen Brown (Tab 4c)
- Dr. Robert Taylor (Tab ad)
- Mr. Victor Boston (Tab 4e)
- Dr. Joe Gaston (Tab 4f)
- Dr. Mary O'Connor (Tab 4g)
- Dr. Edward Sumner (Tab 4h)

Tab.5 (from PSNI papers)

Statements:

- Dr. Maurice Savage (093-006, Tab 5a)
- Nurse Catherine Murphy (093-007, Tab 5b)
- Mr. Patrick Keane (093-010, Tab 5c)
- Mr. Stephen Brown (093-011, Tab 5d)
- Ms. Eleanor Donaghy (093-015-048 and 093-016-049, Tab 5e)
- Joanne Sherratt (now Clingham) (093-017-051, Tab 5f)
- Dr. Mary O'Connor (093-020, Tab 5g)
- Dr. Joe Gaston (093-023, Tab 5h)
- Professor Peter Berry (093-030, Tab 5i)
- Professor Risdon (093-031, Tab 5i)
- Transcript of Dr. Robert Taylor's interview under caution (included in the
- statement of DS William Cross (093-035, Tab 5k)

Reports:

- Dr. Edward Sumner (094-002, Tab 5L)
- Mr. Geoff Koffman (094-007, Tab 5m).
- Medical opinion of Dr. Edward Sumner (094-001, Tab 5n)

Other documents:

- Dr. John Burton's folder of documents (094_013, Tab 5o)
- Schedule of Adam's surgical procedures (Tab 6a)
- Table showing Adam sodium levels and surgical procedures(Tab 6b)
- Urine sodium table(6c)

CORONER'S PAPERS (File 11)

PSNI PAPERS (Files 93 & 94)

ADAM'S MEDICAL NOTES AND RECORDS (Files16, 49-60 inclusive)

APPENDIX 4

BIBLIOGRAPHY

Glasper E. Richardson J. (2006) A Textbook of Children's and Young People's Nursing, Churchill, Livingstone, London: Churchill, Livingstone, Elsevier

Kelsey J. McEwing G. (2008) Clinical Skills in Child Health Practice, Churchill, Livingstone, London: Churchill, Livingstone, Elsevier

McGarvey H. Chambers M. Boore J. (2000) Development and definition of the role of the operating department nurse: A review, Journal of Advanced Nursing 2000 32(5) 1092-1100

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) Code of Professional Conduct, London: Nursing and Midwifery Council www.nmc-uk.org

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) The Scope of Professional Practice, London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992)

The Scope of Professional Practice, London: Nursing and Midwifery Council www.nmc-uk.org

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) Standards for the Administration of Medicines: London: Nursing and Midwifery Council www.nmc-uk.org

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1993) Standards for Records and Record Keeping, London: Nursing and Midwifery Council

Witness Statement Ref. No. 108/1

NAME OF CHILD: Adam Strain

Name: Ms Sally Ramsay

Title:

Present position and institution:

Self-employed independent advisor on children's nursing

Previous position and institution:

Chief Nursing Officer, Portland Hospital for Women and Children

Director of Nursing and Family Services, Great Ormond Street Hospital for Children NHS Trust

Membership of Advisory Panels and Committees:

Safe and Sustainable Children's Heart Surgery, Review panel – 2010

National Clinical Advisory Team – Norfolk, Suffolk and Cambridgeshire Neonatal Services Review – 2010

UKCC – Preliminary Proceedings Committee – 1995-2001

Nursing and Midwifery Council – Investigating Committee – 2001-2005

Previous Statements, Depositions and Reports:

N/A

OFFICIAL USE:
List of reports attached:

Ref:	**Date:**	

Particular areas of interest:

Nursing care of children in hospital.

Clinical governance, in particular risk management.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed:  **Dated:** 16/12/10

Standards for Records and Record Keeping

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

April 1993

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Introduction

1 The important activity of making and keeping records is an essential and integral part of care and not a distraction from its provision. There is, however, substantial evidence to indicate that inadequate and inappropriate record keeping concerning the care of patients and clients neglects their interests through:

1.1 impairing continuity of care;

1.2 introducing discontinuity of communication between staff;

1.3 creating the risk of medication or other treatment being duplicated or omitted;

1.4 failing to focus attention on early signs of deviation from the norm and

1.5 failing to place on record significant observations and conclusions.

2 For these reasons the Council has prepared this standards paper to assist its practitioners to fulfil the expectations it has of them and to serve more effectively the interests of their patients and clients.

3 To meet the standards set out in this document is to honour, in this aspect of practice, the Council's expectation (set out in the 'Code of Professional Conduct for the Nurse, Midwife and Health Visitor') (1) that:

"As a registered nurse, midwife or health visitor you are personally accountable for your practice and, in the exercise of your professional accountability, must:

1 act always in such a manner as to promote and safeguard the interests and well-being of patients and clients;

2 ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients; "

The Purpose of Records

4 The purpose of records created and maintained by registered nurses, midwives and health visitors is to:

4.1 provide accurate, current, comprehensive and concise information concerning the condition and care of the patient or client and associated observations;

4.2 provide a record of any problems that arise and the action taken in response to them;

4.3 provide evidence of care required, intervention by professional practitioners and patient or client responses;

4.4 include a record of any factors (physical, psychological or social) that appear to affect the patient or client;

4.5 record the chronology of events and the reasons for any decisions made;

4.6 support standard setting, quality assessment and audit and

4.7 provide a baseline record against which improvement or deterioration may be judged.

The Importance of Records

5 Effective record keeping by nurses, midwives and health visitors is a means of:

5.1 communicating with others and describing what has been observed or done;

5.2 identifying the discrete role played by nurses, midwives and health visitors in care;

5.3 organising communication and the dissemination of information among the members of the team providing care for a patient or client;

5.4 demonstrating the chronology of events, the factors observed and the response to care and treatment and

5.5 demonstrating the properly considered clinical decisions relating to patient care.

Standards for Records - Key Features

6 In addition to fulfilling the purposes set out in paragraph 4, properly made and maintained records will:

6.1 be made as soon as possible after the events to which they relate;

6.2 identify factors which jeopardise standards or place the patient or client at risk;

6.3 provide evidence of the need, in specific cases, for practitioners with special knowledge and skills;

6.4 aid patient or client involvement in their own care;

6.5 provide 'protection' for staff against any future complaint which may be made and

6.6 be written, wherever possible, in terms which the patient or client will be able to understand.

Standards for Records - Ethical Aspects

7 A correctly made record honours the ethical concepts on which good practice is based and demonstrates the basis of the professional and clinical decisions made.

8 A basic tenet of records and record keeping is that those who make, access and use the records understand the ethical concepts of professional practice which relate to them. These will include, in particular, the need to protect confidentiality, to ensure true consent and to assist patients and clients to make informed decisions.

9 The originator will ensure that the entry in a record that she or he makes is totally accurate and based on respect for truth and integrity.

Standards for Records - Recording Decisions on Resuscitation

10 It is essential that the records on the subject of resuscitation accurately and explicitly reflect any wishes of a patient expressed when legally and mentally competent or those of the patient's next of kin or other significant persons when those circumstances do not apply. This is particularly important when a patient has expressed a wish not to be resuscitated. This is to say that the wishes of a patient, made and expressed when she or he was legally and mentally competent, should be respected.

11 Where the views of the patient and/or those of 'significant others' in relationship to them have not been recorded, but a decision not to resuscitate has been made on clinical grounds by the relevant medical staff, this also should be entered in writing in the medical record and the entry must be signed and dated by the responsible registered medical practitioner. Wherever possible this should be a team decision which, though made by the medical staff, would take the informed views of the nursing staff (and, where applicable, midwifery staff) into account. The patient's family or other significant personal carers should, wherever possible, be consulted.

12 Whether the circumstances in paragraph 10 or paragraph 11 apply, the entry must be able to be located easily and quickly in the medical record and must include a time limit for which it is to apply before review. Nursing and midwifery staff must not enter this decision in the nursing or midwifery record unless it has first been entered in the medical record in the way described in paragraph 11 above.

Standards for Records - Essential Elements

13 In order to fulfil the purpose stated in paragraph 4, to be effective and to meet the standards set out above, records must:

13.1 be written legibly and indelibly;

13.2 be clear and unambiguous;

13.3 be accurate in each entry as to date and time;

13.4 ensure that alterations are made by scoring out with a single line followed by the initialled, dated and timed correct entry;

13.5 ensure that additions to existing entries are individually dated, timed and signed;

13.6 not include abbreviations, meaningless phrases and offensive subjective statements unrelated to the patient's care and associated observations;

13.7 not allow the use of initials for major entries and, where their use is allowed for other entries, ensure that local arrangements for identifying initials and signatures exist and

13.8 not include entries made in pencil or blue ink, the former carrying the risk of erasure and the latter (where photocopying is required) of poor quality reproduction.

14 In summary, the record:

14.1 is directed primarily to serving the interests and care of the patient or client to whom the record relates and enabling the provision of care, the prevention of disease and the promotion of health and

14.2 will demonstrate the chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes.

15 In hospitals or other institutions providing care, a local index record of signatures should be held. Where initials are regarded as acceptable for any purpose, these also should feature in the index, together with the full name in printed form.

The 'Process Approach' or 'Planned Individualised Care' Approach to Nursing and Midwifery Care

16 Given the nature of care plans and records associated with the planned individual care approach, this important aspect of records must satisfy the criteria specified in paragraphs 4 to 15 above. The 'process' approach assists a systematic approach to practice. It also provides a framework for the documentation of that practice. The term therefore describes the continuum of distinctly separate yet interrelated activities of practice, assessment, planning, implementation and evaluation of care.

17 Meticulous and timely documentation provides evidence of the practitioner's actions, the patient's or client's response to those actions and the plans and goals which direct the care of the patient or client.

18 The preparation and completion of care plans will, therefore, in addition to satisfying the criteria set out in paragraphs 4 to 15 above, demonstrate that each step in what is a continuing process has been followed and provides the basis for further goal setting and actions.

19 The making of entries will be organised so that:

19.1 a measurable, up to date, description of the condition of the patient or client and the care delivered can be easily communicated to others and

19.2 the plan and other records complement each other.

20 The practitioner, in applying the process and using the plan, will distinguish between those matters which must be recorded in advance (such as planning and goals) and those which can only be current or slightly retrospective (such as observations and evaluation). Equally, the distinction must be made between entries on papers, (for example, planning forms) which may not be locally retained, and other forms which are part of the clinical nursing or midwifery care records which record changes and events and must be retained.

The Legal Status of Records and Its Implications

21 Any document which records any aspect of the care of a patient or client can be required as evidence before a court of law or before the Preliminary Proceedings Committee or Professional Conduct Committee of the Council (the UKCC) or other similar regulatory bodies for the health care professions including the General Medical Council, the comparable body to the UKCC for the medical profession.

22 For this, in addition to their primary purpose of serving the interests of the patient or client, the records should provide:

22.1 a comprehensive picture of care delivered, associated outcomes and other relevant information;

22.1 pertinent information about the condition of the patient or client at any given time and the measures taken to respond to identified need;

22.3 evidence that the practitioner's common law duty of care has been understood and honoured and

22.4 a record of the arrangements

made for continuity of a patient's care on discharge from hospital.

23 Particular care will be exercised and frequent record entries made where patients or clients present complex problems, show deviation from the norm, require more intensive care than normal, are confused and disoriented or in other ways give cause for concern.

24 In situations where the condition of the patient or client is apparently unchanging, local agreement will be necessary in respect of the maximum time allowed to elapse between entries in patient or client records and the nature of those entries. All exceptional events, however, must be recorded and the Council will expect nurses, midwives and health visitors to exercise suitable judgement about entries in the record.

25 Ownership of the contents of a record would normally be seen as residing with the originator of any particular entry. In practice, however, where the professional practitioner is a salaried employee of the health services, the question of ownership turns on ownership of the document on which the record is made. Ownership does not rest with the patient or client, as the creation of law to grant patient or client access in certain circumstances clearly reveals.

26 Midwives must ensure that they are aware of and comply with the requirements in respect of records set out in the Council's 'Midwives Rules'.

27 It is essential that members of the professions must be involved in local discussions to determine policies concerning the retention or disposal of

all or any part of records which they or their colleagues make. Such policies must be determined with recognition of any aspects of law affecting the duration of retention and make explicit the period for which specific categories of records are to be retained. Any documents which form part of the chronological clinical care record should be retained.

Retention of Obstetric Records

28 All essential obstetric records (such as those recording the care of a mother and baby during pregnancy, labour and the puerperium, including all test results, prescription forms and records of medicines administered) must be retained. Decisions concerning those records which are to be regarded as essential must not be made at local level without involving senior medical practitioners concerned with the provision of maternity and neo-natal services and a senior practising midwife.

29 Those involved in determining policy at local level must ensure that the records retained are comprehensive (in that they include both hospital, community midwifery records and those held by mothers during pregnancy and the puerperium) and are such as to facilitate any investigations required as a result of action brought under the Congenital Disabilities (Civil Liabilities) Act 1976 or any other litigation.

Patient or Client Held Records

30 The Council is in favour of patients and clients being given custody of their own health care records in circumstances where it is appropriate.

Patient or client held records help to emphasise and make clear the practitioner's responsibility to the patient or client by sharing any information held or assessments made and illustrate the involvement of the patient or client in their own care.

31 Evidence from those places where this has become the practice indicates that there are no substantial drawbacks and considerable ethical benefits to be derived from patients or clients having custody of their records. This immediately disposes of any difficulties concerning access and reinforces the discipline that should apply to making entries in records.

32 A small number of instances will inevitably arise, where a system of patient or client held records is in operation, in which the health professional concerned will feel that her or his particular concerns or anxieties (for example about the possibility of child abuse) require that a supplementary record be created and held by the practitioner. To make and keep such a record can, in appropriate circumstances, be regarded as good practice. It should be the exception rather than the norm, however, and should not extend to keeping full duplicate records unless in the most unusual circumstances.

Patient or Client Access to Records

33 With effect from 1 November 1991, patients and clients have had the right of access to manual records about themselves made from that date as a result of the Access to Health Records Act 1990 coming into effect. This has brought such records into line with computer held records which have

been required to be accessible to patients since the Data Protection Act 1984 became operative.

34 These Acts give the right of access, but the health professional most directly concerned (which, in certain cases will be the nurse, midwife or health visitor) is permitted to withhold information which she or he believes might cause serious harm to the physical or mental health of the patient or client or which would identify a third party. The system for dealing with applications for access is explained in the 'Guide to the Access to Health Records Act 1990', published by the Government Health Departments (2).

35 The Council fully supports the principle of open access to records contained in these Acts, and the guidance notes concerning their operation, and trusts that access will not be unreasonably denied or limited.

36 All practitioners who create records or make entries in any records must be aware of the rights of the patient or client in this regard, give careful consideration to the language and terminology employed and recognise the positive advantages of greater trust and confidence of patients and clients in the professions that can result from this development.

Shared Records

37 The Council recognises the advantages of 'shared' records in which all health professionals involved in the care and treatment of an individual make entries in a single record and in accordance with a broadly agreed local protocol. These are seen as particularly valuable in midwifery practice. The Council

supports this practice where circumstances lend themselves to it and where relevant preparatory work has been undertaken. Each practitioner's contribution to such records should be seen as of equal importance. This reflects the collaborative and cooperative working within the health care team on which emphasis is laid by the Council in its 'Code of Professional Conduct for the Nurse, Midwife and Health Visitor'. The same right of access to records by the patient or client exists where a system of shared records is in use. It is essential, therefore, that local agreement is reached to identify the lead professional to be responsible for considering requests from patients and clients for access in particular circumstances.

Computer Held Records

38 The application of computer technology should not be allowed to breach the important principle of confidentiality. To say this is not to oppose the use of computer held records, whether specific to one profession or shared between professions. Practitioners must satisfy themselves about the security of the system used and ascertain which categories of staff have access to the records to which they are expected to contribute important, personal and confidential information.

39 Where computer technology is employed it must provide a means of maintaining or enhancing service to patients or clients and avoid the risk of inadvertent breaches of confidentiality. It must not impose a limit on the amount of text a practitioner may enter if the

consequence is that it impedes the compilation of a sufficiently comprehensive record. The case for it has to be considered in association with the questions of access, patient or client held records, shared records and audit. Local protocols must include means of authenticating an entry in the absence of a written signature and must indicate clearly the identity of the originator of that entry.

The Practitioner's Accountability for Entries Made by Others

40 Irrespective of the type of record or the form or medium employed to create and access it, the registered nurse, midwife or health visitor must recognise her or his personal accountability for entries to records made by students or others under their supervision.

Summary of the Principles Underpinning Records and Record Keeping

41 The following principles must apply:

41.1 the record is directed primarily to serving the interests of the patient or client to whom it relates and enabling the provision of care, the prevention of disease and the promotion of health;

41.2 the record demonstrates the accurate chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes;

41.3 the record and the activity of record keeping is an integral and essential part of care and not a distraction from its provision;

41.4 the record is clear and unambiguous;

41.5 the record contains entries recording facts and observations written at the time of, or soon after, the events described;

41.6 the record provides a safe and effective means of communication between members of the health care team and supports continuity of care;

41.7 the record demonstrates that the practitioner's duty of care has been fulfilled;

41.8 the systems for record keeping exclude unauthorised access and breaches of confidentiality and

41.9 the record is constructed and completed in such a manner as to facilitate the monitoring of standards, audit, quality assurance and the investigation of complaints.

42 Enquiries in respect of this Council paper should be directed to the:

Registrar and Chief Executive
United Kingdom Central Council
for Nursing, Midwifery and
Health Visiting
23 Portland Place
London
W1N 3AF

References

1 'Code of Professional Conduct for the Nurse, Midwife and Health Visitor'; UKCC, London, 1992.

2 'Access to Health Records Act 1990: a Guide for the NHS'; Government Health Departments, 1990.

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

23 Portland Place, London W1N 3AF
Telephone 071-637 7181 Facsimile 071-436 2924

UKCC

Code of Professional Conduct

United Kingdom Central Council for Nursing, Midwifery and Health Visiting

June 1992

United Kingdom Central Council for Nursing, Midwifery and Health Visiting
23 Portland Place, London W1N 4JT
Telephone 0171 637 7181 Facsimile 0171 436 2924

Code of Professional Conduct for the Nurse, Midwife and Health Visitor

Third Edition
June 1992

Each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to:

- **safeguard and promote the interests of individual patients and clients;**
- **serve the interests of society;**
- **justify public trust and confidence and**
- **uphold and enhance the good standing and reputation of the professions.**

As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, must:

1 act always in such a manner as to promote and safeguard the interests and well-being of patients and clients;

2 ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients;

3 maintain and improve your professional knowledge and competence;

4 acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner;

5 work in an open and co-operative manner with patients, clients and their families, foster their independence and recognise and respect their involvement in the planning and delivery of care;

6 work in a collaborative and co-operative manner with health care professionals and others involved in providing care, and recognise and respect their particular contributions within the care team;

7 recognise and respect the uniqueness and dignity of each patient and client, and respond to their need for care, irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problems or any other factor;

8 report to an appropriate person or authority, at the earliest possible time, any conscientious objection which may be relevant to your professional practice;

9 avoid any abuse of your privileged relationship with patients and clients and of the privileged access allowed to their person, property, residence or workplace;

10 protect all confidential information concerning patients and clients obtained in the course of professional practice and make disclosures only with consent where required by the order of a court or where you can justify disclosure in the wider public interest;

11 report to an appropriate person or authority, having regard to the physical, psychological and social effects on patients and clients, any circumstances in the environment of care which could jeopardise standards of practice;

12 report to an appropriate person or authority any circumstances in which safe and appropriate care for patients and clients cannot be provided;

13 report to an appropriate person or authority where it appears that the health or safety of colleagues is at risk, as such circumstances may compromise standards of practice and care;

14 assist professional colleagues, in the context of your own knowledge, experience and sphere of responsibility, to develop their professional competence and assist others in the care team, including informal carers, to contribute safely and to a degree appropriate to their roles;

15 refuse any gift, favour or hospitality from patients or clients currently in your care which might be interpreted as seeking to exert influence to obtain preferential consideration and

16 ensure that your registration status is not used in the promotion of commercial products or services, declare any financial or other interests in relevant organisations providing such goods or services and ensure that your professional judgement is not influenced by any commercial considerations.

Notice to all Registered Nurses, Midwives and Health Visitors

This Code of Professional Conduct for the Nurse, Midwife and Health Visitor is issued to all registered nurses, midwives and health visitors by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. The Council is the regulatory body responsible for the standards of these professions and it requires members of the professions to practise and conduct themselves within the standards and framework provided by the Code.

The Council's Code is kept under review and any recommendations for change and improvement would be welcomed and should be addressed to the:

Chief Executive/Registrar
United Kingdom Central Council
for Nursing, Midwifery and Health Visiting
23 Portland Place
London
W1N 4JT

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

23 Portland Place, London W1N 4JT
Telephone 0171 637 7181 Facsimile 0171 436 2924

The Scope of Professional Practice

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

June 1992

The Scope of Professional Practice

A UKCC Position Statement

Introduction

1 The practice of nursing, midwifery and health visiting requires the application of knowledge and the simultaneous exercise of judgement and skill. Practice takes place in a context of continuing change and development. Such change and development may result from advances in research leading to improvements in treatment and care, from alterations to the provision of health and social care services, as a result of changes in local policies and as a result of new approaches to professional practice. Practice must, therefore, be sensitive, relevant and responsive to the needs of individual patients and clients and have the capacity to adjust, where and when appropriate, to changing circumstances.

2 Education and experience form the foundation on which nurses, midwives and health visitors exercise judgement and skill, these, naturally, being developed and refined over time. The range of responsibilities which fall to individual nurses, midwives and health visitors should be related to their personal experience, education and skill. This range of responsibilities is described here as the 'scope of professional practice' and this paper sets out the Council's principles on which any adjustment to the scope of professional practice should be based. The contents of this paper are set out on page 2.

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Education for Professional Practice

3 Just as practice must remain dynamic, sensitive, relevant and responsive to the changing needs of patients and clients, so too must education for practice. Pre-registration education prepares nurses, midwives and health visitors for safe practice at the point of registration. The pre-registration curriculum will continue to change over time to absorb relevant changes in care as advances are made. Pre-registration education is therefore, a foundation for professional practice and a means of equipping nurses, midwives and health visitors with the necessary knowledge and skills to assume responsibility as registered practitioners. This foundation education alone, however, cannot effectively meet the changing and complex demands of the range of modern health care. Post-registration education equips practitioners with additional and more specialist skills necessary to meet the special needs of patients and clients. There is a broad range of post-registration provision and the Council regards adequate and effective provision of quality education as a pre-requisite of quality care.

Registration and the Code of Professional Conduct for the Nurse, Midwife and Health Visitor

4 The act of registration by the Council confers on individual nurses, midwives and health visitors the legal right to practise and to use the title 'registered'. From the point of registration, each practitioner is subject to the Council's

Code of Professional Conduct and accountable for his or her practice and conduct. The Code provides a statement of the values of the professions and establishes the framework within which practitioners practise and conduct themselves. The act of registration and the expectations stated in the Code are central to the Council's key role in regulating the standards of the professions in the interest of patients and clients and of society as a whole.

5 Once registered, each nurse, midwife and health visitor remains subject to the Code and ultimately accountable to the Council for his or her actions and omissions. This position applies regardless of the employment circumstances and regardless of whether or not individuals are actively engaged in practice. This position will only change if the decision is made by the Council (through clearly established legal processes related to professional misconduct or unfitness to practise due to illness) to remove a name from the Council's register. This reflects the central role which the registration process plays in maintaining standards in the public interest. On the specific question of employment of nurses in the personal social services in general and the residential care sector in particular, the Council recognises that there are ambiguities. These are addressed in paragraphs 20 and 21 of this paper.

The Code of Professional Conduct and the Scope of Professional Practice

6 The Code includes a number of explicit clauses which relate to changes to the scope of practice in nursing, midwifery and health visiting. These clauses are:

> **"As a registered nurse, midwife or health visitor you are personally accountable for your practice and, in the exercise of your professional accountability, must:**
>
> 1 act always in such a manner as to promote and safeguard the interests and well-being of patients and clients;
>
> 2 ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients;
>
> 3 maintain and improve your professional knowledge and competence;
>
> 4 acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner;"

7 The Code, therefore, provides a firm bedrock upon which decisions about adjustments to the scope of professional practice can be made. There are, however, important distinctions relating to the scope of practice in nursing, in midwifery and in health visiting. These are described in the paragraphs that follow the Council's principles for adjusting the

scope of practice. These principles apply to the practice of nursing, midwifery and health visiting addressed later in this paper and to any application of complementary or alternative and other therapies by nurses, midwives or health visitors.

Principles for adjusting the Scope of Practice

8 Although the practices of nursing, midwifery and health visiting differ widely, the same principles apply to the scope of practice in each of these professions. The following principles are based upon the Council's Code of Professional Conduct and, in particular, on the emphasis which the Code places upon knowledge, skill, responsibility and accountability. The principles which should govern adjustments to the scope of professional practice are those which follow.

9 The registered nurse, midwife or health visitor:

9.1 must be satisfied that each aspect of practice is directed to meeting the needs and serving the interests of the patient or client;

9.2 must endeavour always to achieve, maintain and develop knowledge, skill and competence to respond to those needs and interests;

9.3 must honestly acknowledge any limits of personal knowledge and skill and take steps to remedy any relevant deficits in order effectively and appropriately to meet the needs of patients and clients;

9.4 must ensure that any enlargement or adjustment of the scope of personal professional practice must be achieved without compromising or fragmenting existing aspects of professional practice and care and that the requirements of the Council's Code of Professional Conduct are satisfied throughout the whole area of practice;

9.5 must recognise and honour the personal accountability borne for all aspects of professional practice and

9.6 must, in serving the interests of patients and clients and the wider interests of society, avoid any inappropriate delegation to others which compromises those interests.

10 These principles for practice should enhance trust and confidence within a health care team and promote further the important collaborative work between medical and nursing, midwifery and health visiting practitioners upon which good practice and care depends.

11 The Council recognises that care by registered nurses, midwives and health visitors is provided in health care, social care and domestic settings. Patients and clients require skilled care from registered practitioners and support staff require direction and supervision from these same practitioners. These matters are directly concerned with standards of care. This paper, therefore, also addresses the matter of the 'identified' practitioner, practice in the personal social services

and residential care sector and support for professional practice.

The Scope and 'Extended Practice' of Nursing

12 The practice of nursing has traditionally been based on the premise that pre-registration education equips the nurse to perform at a certain level and to encompass a particular range of activities. It is also based on the premise that any widening of that range and enhancements of the nurse's practice requires 'official' extension of that role by certification.

13 The Council considers that the terms 'extended' or 'extending' roles which have been associated with this system are no longer suitable since they limit, rather than extend, the parameters of practice. As a result, many practitioners have been prevented from fulfilling their potential for the benefit of patients. The Council also believes that a concentration on 'activities' can detract from the importance of holistic nursing care. The Council has therefore determined the principles set out in paragraphs 8 to 10 inclusive to provide the basis for ensuring that practice remains dynamic and is able readily and appropriately to adjust to meet changing care needs.

14 The reality is that the practice of nursing, and education for that practice, will continue to be shaped by developments in care and treatment, and by other events which influence it. This equally applies to midwifery and health visiting.

In order to bring into proper focus the professional responsibility and consequent accountability of individual practitioners, it is the Council's principles for practice rather than certificates for tasks which should form the basis for adjustments to the scope of practice.

The Scope of Midwifery Practice

15 The position in relation to midwifery practice is set out in the Council's Midwife's Code of Practice. This indicates that it is the individual midwife's responsibility to maintain and develop the competence which she has acquired during her training, recognising the sphere of practice in which she is deemed to be equipped to practise with safety and competence. It also indicates that, while some developments in midwifery become an essential and integral part of the role of every midwife (and are subsequently incorporated into pre-registration education), other developments may require particular midwives to acquire new skills because of the particular settings in which they are practising. The importance of local policies which are in accord with the Council's policies and standards and the guidelines issued by the National Boards for Nursing, Midwifery and Health Visiting is self-evident. The importance of the midwife practising outside the area of her employing authority or outside the National Health Service discussing the full scope of her practice with her supervisor of midwives is emphasised in the Midwife's Code of Practice.

16 It can be seen from this position that it is accepted by the Council that some developments in midwifery care can become an integral part of the role of all midwives and other developments may become part of the role of some midwives. The Council believes that the Midwife's Code of Practice, cited above, and the Code of Professional Conduct, together provide key principles to underpin the scope of midwifery practice. These are now supplemented by those stated in paragraphs 8 to 10 inclusive of this paper.

The Scope of Health Visiting Practice

17 The position of health visiting differs from that of nursing and midwifery, as there are frequent occasions when the full contribution of health visitors may not find expression where it is most needed. There is, for example, often a concentration on the role of the health visitor in relation to those in the under-five age group at the expense of other groups in the community who need, and would benefit from, the special preparation and skill of health visitors. These circumstances have the effect of constraining practice and limiting the degree to which individuals and communities are able to benefit from the knowledge and skill of health visitors. There is merit in allowing health visitors, where they judge it to be appropriate, to use the full range of their skills in response to needs identified in the pursuit of their health visiting practice. To single out any aspect of practice would be unwise but, where health and nursing need is identified, the health

visitor is well placed to determine what intervention may be necessary and able to draw on both her nursing and health visiting education.

18 The community setting of health visiting practice, the relationship between numerous agencies and services and the health visitor's professional relationship with clients and their families are factors which must be taken into consideration. The health visitor, in all aspects of her practice, is subject to the Council's Code of Professional Conduct and should also satisfy the requirements of paragraphs 8 to 10 inclusive of this paper.

Practice and the 'Identified' Nurse, Midwife and Health Visitor

19 The Council recognises that, in a growing number of settings, patients and clients will be in the care of an 'identified' practitioner. The practitioner may be identified as the 'named' practitioner or as the primary, associate or sole practitioner providing nursing, midwifery or health visiting care. In such roles, individuals assume responsibility for coordinating and supervising the delivery of care, drawing on the general and special resources of colleagues where appropriate. Professional practice naturally involves recognising and accepting accountability for these matters. The Council expects that practitioners will recognise the need to provide all necessary support for colleagues and ensure that practice is underpinned by the required knowledge and skill. The Council equally expects

that practitioners identified in one of these ways will be fully prepared for, and supported, in this key role.

Practice in the Personal Social Services and Residential Care Sector

20 The Council recognised that the community nursing services have a duty to provide a nursing service to those in need of nursing care in the personal social services and residential care sector. Registered nurses who are employed in this sector, whether in homes or in the provision of other services, remain accountable to the Council and subject to the Council's Code of Professional Conduct, even if their posts do not require nursing qualifications. In this regard, as explained in paragraph 5 of this paper, the position of such nurses is the same as that of nurses engaged in direct professional nursing practice.

21 The Council requires that registered nurses employed in such circumstances will use their judgement and discretion to identify the nursing needs of residents and others for whom they may have responsibility, and will comply with any requirements of the Council. The Council expects that employers will recognise the advantages to the personal social services and residential care sector which result from the employment of registered nurses.

Support for Professional Practice

22 Nurses, midwives and health visitors require support in their work. In institutional and community settings, a range of support staff form part of the team. The development of the health care assistant role is linked with a form of vocational training. The Council does not have a direct role in this training, but recognises that this development has an impact upon aspects of care and on the practice and standard of nursing, midwifery and health visiting, for which the Council is responsible.

23 The Council's position in relation to support roles is as follows:

23.1 health care assistants to registered nurses, midwives and health visitors must work under the direction and supervision of those registered practitioners;

23.2 registered nurses, midwives and health visitors must remain accountable for assessment, planning and standards of care and for determining the activity of their support staff;

23.3 health care assistants must not be allowed to work beyond their level of competence;

23.4 continuity of care and appropriate skill/staff mix is important, so health care assistants should be integral members of the caring team;

23.5 standards of care must be safeguarded and the need for patients and clients, across the spectrum of health care, to receive skilled professional nursing, midwifery and health visiting assessment and care must be recognised as of primary importance;

23.6 health care assistants with the desire and ability to progress to professional education should be encouraged to obtain vocational qualifications, some of which may be approved by the Council as acceptable entry criteria into programmes of professional education and

23.7 registered nurses, midwives and health visitors should be involved in these developments so that the support role can be designed to ensure that professional skills are used most appropriately for the benefit of patients and clients.

Conclusion

24 The principles set out in paragraphs 8 to 10 inclusive of this paper should form the basis for any decisions relating to adjustments to the scope of practice. These principles should replace the system of certification for specific tasks. They provide a realistic, effective and rational approach to adjustments to professional practice.

25 This change has consequences for managers of clinical practice and professional leaders of nursing, midwifery and health visiting, who must ensure that local policies and procedures are based upon the principles set out in this paper and in the Council's Code of Professional Conduct. Any local arrangements must ensure that registered nurses, midwives and health visitors are assisted to undertake, and are enabled to fulfil, any suitable adjustments to their scope of practice.

26 This statement sets out the Council's position relating to the scope of professional practice of the professions it regulates, to the 'identified' practitioner, to practice in the residential care sector and to support staff. The Council hopes that this statement, and the principles which it sets out, will provide a clear framework for the logical and desirable development of practice and for the management of practice and care teams. The framework provides for greater flexibility in practice and for enhancing the contribution to care of nurses, midwives and health visitors. Above all, the framework and the principles reflect the personal responsibility and accountability of individual practitioners, entrusted by the Council to protect and improve standards of care.

27 Enquiries in respect of this Council paper should be directed to the:

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