SALLY G. RAMSAY
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Ms. Bernie Conlon
The Inquiry into Hyponatraemia-related deaths in Northern Ireland
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Bernie

Re: Adam Strain

I enclose, as requested, a signed note regarding the involvement of Ms. T. Durack in preparing my Supplemental Report of 21st June, 2011.

I also enclose copies of referenced documents that I believe you have not previously been sent. Some referenced documents were too big to be printed. They are available through the relevant websites and details are given in my reports.

Regards

Sally Ramsay 8/3/12

Sally Ramsay

ADAM STRAIN

COMMENT IN RELATION TO SUPPLEMENTAL REPORT DATED 21ST JUNE, 2011

As noted in the introduction to my Supplemental Report of 21st June, 2011 and with agreement from the Inquiry, I sought the advice of Ms. Teresa Durack in responding to the questions presented to me as Supplemental Queries, in a letter dated 26th May, 2011.

In requesting Ms. Durack's help I gave her a brief background in relation to Adam's operation. I summarised the queries given to me and gave her my draft responses. Ms. Durack was asked to comment on my draft responses and to give additional information as necessary.

Ms. Durack responded accordingly and sent copies of documents that she thought I may find helpful. She noted her agreement with my responses and gave useful additional information.

I included her specific advice in the following sections of my report:

- The composition of the nursing team and guidance available in 1995. (1 (i) paras 1&2)
- Personnel responsible for signing all records used during the operation.(ii & iii)
- Recording of personnel present during an operation (Question vii)
- Anaesthetic nursing – confirmation of role and education in 1995 and currently. (2(i))
- Operating Department Technicians/Assistants/ Practitioners– education and development since 1990's. (2 iv)

S. G. Ramsay 8/3/12

S. G. Ramsay

Glaspe v Richardson (2006)

A Textbook of Children's & Young People's Nursing

Box 7.2

Criteria for choosing an assessment tool or device

- Developed for the purpose: the aspect of the child/family's state, behaviour, feelings, etc. that you are wanting to measure/assess.
- Tested and validated in this age group.
- Tested and validated in this clinical context, e.g. in children with same or closely related condition.
- Culturally appropriate.
- Appropriate for and acceptable to the specific child/young person and family, e.g. the child's cognitive level.

NNING CARE

er or not a formal care plan is written down, some f planning takes place before any action is taken. n assessment findings (and on what they are hop- achieve if goals have been set), the planners iden- ilable options and make decisions about what to be done. Chapter 14 goes into detail about how e can be used to inform such decisions, not with- g the influence of resource availability, patient and hoice or other context of care factors. The plan of a communication tool and makes clear to all con- who will be doing what, when and how. It can be le as a checklist or as complex as a step-by-step ent of a procedure with timed goals and expected es: the detail and complexity of the plan depends communication need. A plan in the child's home ll be used to inform a bank nurse providing respite ll need to be very detailed; a plan for a child seen with a fever may consist of a standard form with ions to be ticked by whoever completes them ace to write additional, individualised actions if ed).

plans may be based on standard plans or pathways Standard care pathways that have been developed dence and expert opinion are one way of imple- g evidence-based practice. Care pathways (also as integrated care pathways) set out detailed steps management of patients with a particular problem ergoing a specific procedure. Ideally, they are devel- the multidisciplinary team and reflect standardised d treatment as well as expected progress (National ic Library for Health 2003). To date, care pathways en mainly implemented in hospitals where care is edictable but standardised approaches to care in d school settings may be just as appropriate in umstances. As computer records and systems throughout the health service, 'e-pathways' will vidence-based standards to be better individualised individual differences to be analysed to provide d evidence (de Luc & Todd 2003).

Evidence-based Practice

The integrated care pathway as an audit tool

Staff in a paediatric oncology unit aimed to improve care for children with fever and neutropenia by introducing an integrated care pathway. Guidelines for neutropenia were examined and a retrospective analysis of notes undertaken to study what was happening before a pathway was introduced. Following the introduction of the pathway, audit findings revealed variances in practice and identified areas for improvement such as referral to dieticians, types of investigations ordered and time taken to administer the first dose of antibiotics, particularly at night. Evidence from the audit was used to amend the pathway and improve practice (Selwood 2000).

SUPPORTING DECISION MAKING

Those planning care will be any combination of health professionals, the child/young person and family members. A key role for the nurse working in partnership to plan care is to support decision making by the child/young person and family. The first step is to assess their decision making preferences, not an easy task but one that acknowledges them as equals and establishes that their experiences and perspectives are valued and will be taken into account.

Activity

Think about your own most recent consultation with a doctor:

- How involved were you in the decision about what action to take?
- How involved would you have preferred to be?
- Having thought about this last question, choose your preference for that particular encounter from the bullet list below:
- I would prefer to make the decision myself with information only.
- I would prefer to make the decision myself considering the doctor's view.
- I would prefer the doctor to make the decision but considering my views.
- I would prefer the doctor to make the decision.

Having been involved in the decision about what to do, you are more likely to adhere to the course of action than if someone else has decided for you. As long ago as 1977, a doctor writing in the *Lancet* suggested that if doctors 'were willing to let go of the notion that they are responsible for controlling their patients', then patients who wanted to could 'make informed decisions on the basis of their own values' (Slack 1977). Not all parents and children will want to participate in

Kelsey & McEwing (2008) Clinical Skills in Child Health Practice

e impact of their contributions on the other and respond
)priately. Be aware of cultural influences regarding both
l and non-verbal communication, while avoiding the use
:reotypical behaviours.

d and parent participation

lren and parents must be given the opportunity to make
concerns known and to ask questions, which should be
ered honestly. Remember that it is easy to assume that
ren are routinely included in any discussion merely because
are in the room (Fig. 2.11; Pengelly 2003). Offer to speak
ildren separately if they wish to do so (e.g. some children
ıding a diabetic outpatient clinic may wish to speak to the
:tic specialist nurse on an individual basis).
ealthcare professionals can assist parents empower their
by acquiescing to such requests. Other children may
confidence from the presence of their parents (Fig. 2.12);
may ask parents to speak on their behalf to either give
in information, to remember information more accurately
clarify or reiterate information later (Young et al 2003).
nts can monopolise discussions, thus inhibiting the child's
ribution, which may be further compounded by lack of
, for example in an outpatient clinic when extra time is
allocated to allow child participation (van Dulmen 1998).
context of a situation can also affect understanding, as
)ients of information may choose to concentrate on posi-
aspects of the situation, resisting attempts to address seri-
issues indicating potentially unwelcome but likely future
:lopments.

nmarise

ıphrasing the discussion is a useful technique to con-
ı that all parties have the same understanding of the
ɔgue that has occurred and any further action that has
:e taken. During this process all parties should have the
ortunity to explain in their words what has been said or

. 2.11 • Do not assume that a child is included in any discussion
:ly because she or he is in the room.

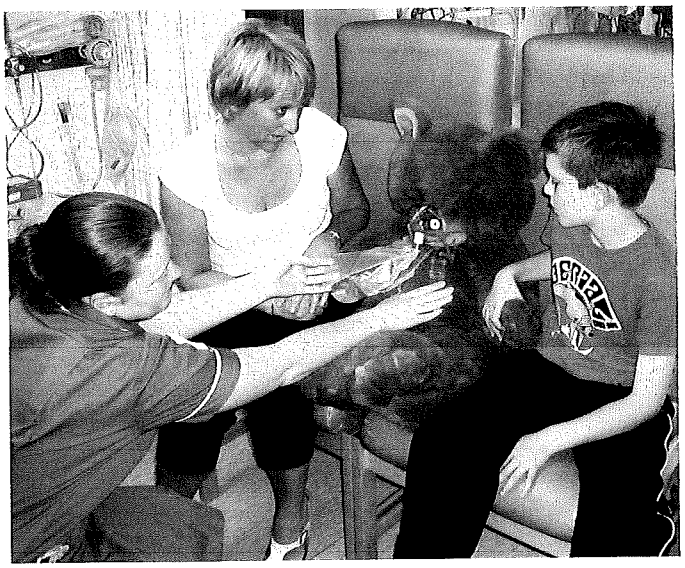

Fig. 2.12 • Children may gain confidence from the presence of their parents.

agreed, as this may vary from individual to individual; this is more reliable than simply asking if an understanding has been reached.

Make a plan for further discussion as appropriate to the situation, for example for what is to be discussed at the next outpatient appointment or on receipt of medical investigation results. If the child is an in-patient it is preferable to suggest 'later today' than a definite time such as 3 p.m., as unforeseen circumstances can arise to prevent this agreement being kept, resulting in the child or parents feeling let down. Assurances should be given to the child and parents that they do not have to wait until the agreed time if they are anxious or worried.

Recognise that in an emergency situation decision making is often rushed, without the benefit of time. When the situation is stable it should be revisited to allow reflection on any potential consequences to ensure that a suitable level of understanding is achieved and any unresolved issues are dealt with. Children should be given an opportunity to discuss their understanding of events to enable clarification of any misconceptions they may have of their circumstances.

Written guidelines, such as a laminated instruction sheet given to parents being taught how to administer wet wraps, may be helpful. This increases their confidence that they are proceeding correctly, making it a better experience for all concerned.

Conclude

Give the child and parents a further opportunity to raise issues or concerns, thank them for their input, then engage in social discourse to bring the encounter to a close. Record the discussion in all relevant documentation.

NHS Executive

THE EMPLOYMENT OF OPERATING DEPARTMENT PRACTITIONERS (ODPs) IN THE NHS

To:
Health Authorities (England) - Chief Executives
NHS Trusts - Chief Executives
NHS Trusts - Nurse Executive Directors
NHS Trusts - Human Resource Directors
NHS Trust Chief Pharmacists

cc (info)
Primary Care Groups – Chief Executives
Community Health Councils – Chief Officers
Association of Community Health Councils in England and Wales
Professional , Regulatory and Patient Organisations
The Federation of Recruitment and Employment Services
The Independent Healthcare Association

Further details from:
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2E56
Quarry House
Quarry Hill
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Summary

Employers are asked to ensure that the employment of ODPs is limited to those whose names appear on the voluntary register held by the Association of Operating Department Practitioners and that any practitioner not so registered is appropriately supervised.

The degree of supervision should be determined by the Operating Department Manager in collaboration with the Clinical Director, Senior Consultant Surgeon and Senior Consultant Anaesthetist and other members of the theatre team, as appropriate.

This guidance applies equally to:

a) staff employed in the private and voluntary sector and who provide services on your behalf to patients and clients;
b) staff supplied to you by employment agencies.; and
c) staff working as bank staff.

You are asked to ensure that your arrangements for the provision of such services are confined to organisations complying with these requirements

Development and definition of the role of the operating department nurse: a review

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Development and definition of the role of the operating department nurse: a review

In the current cost-conscious National Health Service (NHS), the role of the nurse during anaesthesia and surgery is one that has interested health service managers keen to know what happens behind the closed doors of the operating department. It is clear that if nurses working within this specialized setting are to secure a future in providing care for surgical patients, then it is important to clarify and articulate exactly what it is that their role involves. The aim of this paper is to examine the role of the operating department nurse. First, it will illustrate how the role of the nurse has evolved alongside medical and technical advances in surgery, particularly in the last century. Second, it will highlight that while definition of the role has received attention in the North American literature, references in the British literature as to what it is that operating department nurses do, are scant. Finally, it will address the evolving role of the contemporary perioperative nurse highlighting the changes and challenges that nurses who work within this setting are currently facing. It is suggested here that nurses need to engage in role definition in order to be clear about their direction for the future, particularly within the fast changing, technologically driven environment of the operating department.

Keywords: operating department, operating department nursing, perioperative role, role definition, operating theatre

INTRODUCTION

The role of the operating department nurse has been under much scrutiny recently in the UK. As a result of the cost-driven culture that has prevailed in the National Health Service (NHS), managers have questioned the value of a role which is largely hidden from view. At

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present, there is little tangible and convincing evidence upon which British nurses in the operating department can secure their future. Nurses themselves have suggested that they should take a more active interest in defining their practice and in researching their role (McGee 1991). However, as yet the theoretical base for nursing practice has been slow to emerge. As a basis for further theoretically driven work, the purpose of this paper is to examine the development and definition of the role of the operating department nurse up to the modern day.

Background: the development of surgery

Surgery has been carried out for thousands of years (Wicker 1991). In Europe, there are few detailed records of surgery until the Renaissance when surgery increased in prevalence with curious scientists striving to explore and heal the human body. However, the rates of infection and mortality were high and those who survived were frequently badly maimed by crudely executed procedures.

Most surgery was carried out by barbers, men skilled in the craft of surgery (but without a formal medical training) and who were members of the Company of Barber-Surgeons, formed in 1540 (Meade 1968). Surgery was selective and generally only given to those who could afford it, although this was no guarantee of success. The Royal College of Surgeons was formed in 1800 (Meade 1968). However, in the absence of anaesthetic techniques, surgery was severely constrained by what the conscious patient could bear and the speed at which the operator could work (Hector 1970). Thus, surgery was mainly external and dependent on the nerve rather than the ability of the surgeon.

By the turn of the 20th century, the scope of surgery had increased dramatically as a result of the following scientific advances (Williams 1989):

- anaesthesia with ether (discovered in 1846);
- antisepsis (1867);
- asepsis (1886);
- antibiotics (1929).

Operations which previously had been considered fatal or impossible were performed with increasing regularity, skill and success. Parallel to these advances came the development of more refined equipment, complex instrumentation and improved suture and wound dressing material, meaning that patients were increasingly less likely to die from pain-induced shock, infection or haemorrhage.

Increased knowledge and understanding about asepsis also meant that the earlier practice of operating on the kitchen table in the patient's home became inappropriate (Bradley *et al.* 1988). By the late 1800s a specially constructed room for surgery was provided, furnished with the modern equipment of the time. Consequently at this time there was a need for preparation and maintenance of the equipment, as well as assistance in using it (Kneedler & Dodge 1991).

The surgical assistant

The earliest reference to the need for surgical assistance was by Hippocrates (Groah 1983). Pictures from the Middle Ages indicate that assistants restrained patients during unpleasant and painful procedures and it seems that this role fell to able-bodied men rather than women, perhaps because men possessed the physical attributes to restrain writhing patients (Meade 1968).

Medical advances in the ensuing centuries led to the establishment of hospitals and the development of nurse training programmes in the UK (1860) and in the USA (1873). By 1880, the operating department rotation had become a routine part of the nursing general training programme (Kneedler & Dodge 1991). The role of assisting the surgeon fell to nurses because they possessed the qualities that were required for surgical work in this new era. In contrast to the physical attributes required in earlier times, the surgical assistant also needed to have the qualities of diligence and obedience.

Operating department nursing as a speciality

By the end of the 19th century, operating department nursing was of such prestige that it became recognized as nursing's first speciality (Clemons 1976). Nursing duties at that time amounted to controlling the patient's environment, preventing infection, preparing the necessary equipment and providing care for the patient during surgery (Luce 1901, Hector 1970). A skilled nurse was allocated to the operating department and she was responsible for the 'at table' activities involved in attending the surgeon. She required an understanding of the idiosyncrasies of each surgeon to ensure that each operation ran smoothly. As a result of the status involved in working with the surgeon, the role of the operating department nurse was seen as one of prestige and great responsibility (Wicker 1987, Kneedler & Dodge 1991). Other activities, such as assisting in the anaesthetic and recovery rooms, were carried out by ward staff who stayed with the patient, provided necessary care or observation during surgery, and then returned to the ward with the patient where they cared for them until discharge. Therefore, it was not uncommon for a nurse to provide continuous care for the patient before, during and after surgery, an idea similar to named nursing (National Association of Theatre Nurses (NATN) 1992).

Given the dearth of literature, it is possible to gauge some of the nursing activities within the operating department by exploring photographs of operations. Photography was a popular pastime, as early operating

departments were places, where the drama of surgery could be watched by the public in the same way that a play would be. Photography was also how innovative surgeons could disseminate information about new techniques. From such photographs, Apple (1988) suggested that nurses in operating departments undertook an amazing array of tasks, but in many cases were portrayed as acting under the supervision of surgeons. Despite this interesting perspective, it is difficult to judge the content of the nursing role from such a limited exposure as it is likely that at least some photographs were staged.

The world wars, 1914–1918 and 1939–1945, had a profound effect on the role of the nurse in general and on the role of the operating department nurse in particular. Demographic and social changes occurred, meaning that the workforce available to nursing generally increased. Horrific war injuries sustained from the ever-advancing military technology resulted in the development of pioneering new surgical techniques and equipment. Surgery became increasingly specialized and aggressive. In North America, the scope of the nursing role increased and nurses adopted a more proactive role in the management of patient care (Kneedler & Dodge 1991). However, the portrayal of events by Bradley *et al.* (1988) depicted that this was not so evident in British nursing at that time and operating department nursing extended little beyond an endless succession of housewifely duties.

In the post-war years, technological advancement had considerable impact on the nurse's role. The 1950s and 1960s saw the introduction of presterilized swabs, disposable syringes and preset instrument trays. The need for sterilized equipment became so great that the centralization of surgical services took place. Central sterile supply departments (CSSD) were developed with a specific remit to sterilize equipment and dressings. Musgrave Park Hospital in Belfast became a pioneer hospital for this service in the early 1960s (NATN 1989). The ultimate effect was that operating department nursing in the late 1960s involved considerably less housework than in the previous two decades.

The need for professional organizations

Following each of the two world wars, there were fears women would lose their newly acquired public roles. American operating department nurses in particular voiced concern about this fear. However, educators and managers were increasingly questioning the value of a role which seemed to be so technical (Groah 1983, Shoup 1988). Student nurse rotations to the operating department decreased, as did the profile of operating department nurses (Kneedler & Dodge 1991). By the late 1940s, this was a great source of concern for nurses. Subsequently, a group of nurses formed the Association of Operating Room Nurses (AORN) as the first professional organization to represent the views of nurses engaged in the provision of nursing care to patients undergoing surgery (Driscoll 1976).

Similar concerns were voiced in the UK. Conditions were poor and nurses within the operating department felt isolated from their ward colleagues (Bradley *et al.* 1988, NATN 1989). As a result of these increasing concerns in 1964, Daisy Ayris, a Leeds nurse, formed NATN to represent British operating department nurses (NATN 1989).

The setting up of these two professional organizations was a landmark in the history of operating department nursing. Two collective bodies of nurses now existed, their function to secure a future for operating department nursing and to provide patients undergoing surgery with a high standard of nursing care. In the following years, professional organizations were formed in other European countries culminating in the formation of the European Operating Room Nurses Association (EORNA) in 1980. The concern for professional collectivity in the provision of nursing care within the operating department had clearly become an international issue.

Definitions of operating department nursing

Although it was reported that operating department nursing was the first speciality within the nursing profession, it was some time before the first formal definition of practice appeared. In fact, it was some 70 years between the time when operating department nurses were first formally employed by hospital authorities and the time when the first definition of operating department nursing actually emerged.

Definitions from the USA

The first formal attempt to define operating department nursing came from the AORN:

> Professional nursing in the operating room is the identification of the physiological, psychological and sociological needs of the patient and the development and implementation of an individualized programme of nursing actions, based on the knowledge of the natural and behavioural sciences, to restore or maintain the health and welfare of the patient before, during and after surgical intervention (AORN 1969, p. 44).

In the following years, further adaptations of this definition emerged. It was recommended that the term perioperative role be used rather than operating room nursing (AORN 1978). This was replaced in 1985 by the term perioperative nursing practice (AORN 1985) to indicate that the remit of operating department nursing was continuing to evolve. The term perioperative begins with the decision for surgery and ends with the resolution of

surgical sequelae, when the patient is finally discharged from the care of the surgical team either through post-operative evaluation at home or in the outpatient clinic (AORN 1978, 1985). Therefore, the definition of the remit of perioperative practice is immense.

Later, the term perioperative nursing was adopted as further reinforcement that the practice setting of the nurse had shifted from its geographical boundary inside the operating room to a more temporal orientation represented by the divisions of preoperative, intraoperative and post-operative nursing (AORN 1993).

Definitions from the UK

It was difficult to find an explicit definition of British operating department nursing. The literature is replete with references as to what the role of the nurse in the operating department entails, but mostly these are based on personal opinion. This was of particular interest because operating department nursing is frequently referred to as occurring 'behind closed doors' (Bolger 1988, p. 66), the implication being that nursing activities in the operating department are surrounded by mystery and intrigue.

Jones (1990) described the role of the operating department nurse as follows:

> The theatre nurse is in a unique privileged position as she/he becomes increasingly involved with the curative/palliative technical treatments provided by medical staff. She/he is the link between what are often stressful, complicated, technical procedures associated with the diseased condition and mental functions which are so critical to the patient's comfort and so important to him as a person.
>
> Theatre nursing is assisting the surgical patient and acting as his advocate in the performance of physical and psychological activities that he would undertake unaided if he had the necessary strength, will or knowledge. The theatre nurse aims to give vital care and support throughout this vulnerable time and ensures the individual is independent of such assistance as soon as possible (p. 9).

Both statements were adapted from previous definitions of nursing by Henderson (1966) and Roper *et al.* (1980). As a result, both statements were aimed at general nursing and in themselves do not reflect any specialist philosophy of operating department nursing.

It was observed that the term perioperative also appeared in the UK literature. Frost (1982) and Mazza (1985) mention perioperative nursing, Brigden (1988) refers to perioperative care and Brown (1994) refers to a perioperative model of nursing. However, such interpretations of the term perioperative are ambiguous. Frost (1982) reports that perioperative involves visiting patients pre- and post-operatively. Carrington (1991) equates the term with the intraoperative period. Mazza (1985) and McGee (1991), on the other hand, give a direct rendition of the AORN's definition of the perioperative role (AORN 1978). Both Mazza (1985) and Brigden (1988) imply that perioperative care and the nursing process are synonymous, when in actual fact the AORN definitions relating to the term 'perioperative' (AORN 1978, 1985, 1993) acknowledge that the nursing process is only a component of an entire philosophy of nursing. Wynne (1991) states that perioperative nursing is a term describing the scope and practice of nursing in surgical settings and elaborates that:

> Such a perioperative practice concept brings together both traditional and expanded nursing activities during intraoperative care, preoperative and postoperative patient education, counselling, assessment, planning and evaluation functions ... Within such a conceptual framework for the practice of perioperative nursing, a description of a comprehensive combination of head and hand nursing emerges (p. 3).

The issue of defining operating department nursing highlights the heavy influence which literature from the USA has had on nursing in the UK. The term perioperative was adopted informally by British nurses before any national clarification or endorsement took place. It was only in 1991 that there was a public adoption of the term perioperative by the NATN when it redefined its aims (Nightingale 1993). However, definition of the term in the context of British nursing has yet to emerge.

Thus, in the UK literature there is not only a distinct lack of clarity about the definition of what exactly operating department nursing consists, but also a high degree of ambiguity in the descriptive terms used. As previously stated, the remit of the perioperative role is immense, from the early preoperative phase to the discharge of the patient from care. This in itself presents problems in terms of extrapolating a nursing contribution to care, as the activities carried out at different stages of the perioperative trajectory are so varied. In actuality, any nurse in the outpatient department, intensive care or surgical ward is potentially carrying out perioperative nursing.

Despite the lack of a UK definition of operating department nursing, there is no shortage of personal interpretation of what the role involves. However, these interpretations have involved the tendency to focus on the specifics of the role, rather than the overriding orientation of nursing care. According to the AORN (1978), 'role' refers to expected behaviour patterns and, specific to operating department nursing, the range of clinical activities performed during the preoperative, intraoperative and postoperative phases. In the absence of a British definition of operating department nursing, it is to these specific role behaviours that the focus now turns.

The operating department nurse: roles and responsibilities

There is a proliferation of papers relating to the actual components of the role that operating department nurses undertake, and some interpretations of the nursing role in the operating department are clearer and more developed than others. Regardless of individual viewpoints, there is a general consensus that the role of the nurse in the operating department is not straightforward. Plowes (1991), Carrington (1991) and West (1993) have suggested that an inherent complexity in the role has made it difficult to define. West (1993) believes that the role of the operating department nurse should only be considered in the light of its contextual difficulties. Similarly, Grundemann (1970) states that clarifying the role is complicated by the social and physical structure of typical hospital operating suites, usually isolated from other patient care areas.

Analysis of the role of the nurse in the operating department can be approached from different perspectives. Researchers have tended to look at role components in a collective way by exploring the patient-related, environmental and medical/technical tasks which need to be performed (for example, Grundemann 1970). Texts, on the other hand, have expounded the nursing role under temporal phases of care, such as the preoperative, the intraoperative, and the postoperative periods and the tasks required of the nurse during each of these phases (e.g. Warren 1983, Kaczmarowski 1987, Kneedler & Dodge 1991, West 1992a).

Further, there is no clear agreement as to whether the role of the nurse in the operating department is one that is dependent on, or independent of the medical profession. Grundemann (1970) suggested that the frame of reference for nursing action had shifted from its earlier concentration on disease and the medical diagnosis to the individualized care of each patient. Consequently, the idea of assisting the surgeon by handing instruments, while at the same time caring for the patient during the operative procedure, can create ambivalence. Dodds (1991) viewed operating department nursing as having an independent role in relation to identifying the needs of each patient, being professional, offering individualized care, being totally accountable and advocating for the patient. While she highlighted the independent function of nursing there must be an acknowledgement that much of the clinical practice of nursing, especially in the operating department, is actually defined by, and under the control of the medical profession. Therein lies an important consideration. The reality of operating department nursing is that there are indisputably nursing actions which are in response to medical orders and treatment during anaesthesia and surgery. For example, the type of wound dressing used at the end of an operation may be controlled by the surgeon, the role of the scrub nurse is medically influenced, and so too is the role of the nurse in assisting the anaesthetist. However, this is not only an issue pertinent to operating department nursing (Turner 1987).

West (1992b) focused on the use of the nursing process as a method for providing nursing care in four hospital settings, one of which was the operating department. Although she did not examine definitions of nursing, she concluded on the basis of this work and as a result of personal experience, that the notion of caring is important to operating department nurses. However, operating department nursing does not have an exclusive monopoly on caring as it is a more generalized concept relating to the wider field of nursing (Leininger 1981, Watson 1988). Apart from caring, West (1993) believes that task elements are also important. She uses the term 'professional duality' to describe this combination of two important components, the emotional and the functional (p. 22). Similarly, Carrington (1991) states that the role combines the technical knowledge and expertise associated with the sophisticated instruments, techniques and drugs in current use, and the basic nursing skills acquired through training and experience that are vital to the care of the patient. In all, she states that it is the nurse's responsibility to care physically and mentally for the patient and to protect them from physical harm, while still considering their personal dignity.

Some of the statements proffered regarding the role of the operating department nurse are more abstract. Plowes (1991) offers a rather vague description of the role when she describes it as 'being there'. While she gave no further elaboration, she does reflect one psychological component of operating department nursing which has also been identified by nurse researchers in other clinical areas, that of presence (Ersser 1998).

Kalideen (1994) set out to explore why operating department nurses chose this specialist area and by doing so, she helped to illuminate certain issues relating to the nature of nursing. She used a grounded theory approach involving interviews with a convenience sample of 15 post-registered nurses undertaking a course in operating department nursing. While her study was small and localized, Kalideen reported that the nursing role within the operating department was defined as 'providing holistic care, monitoring and maintaining a safe environment and ensuring therapeutic activities were practised to a high standard' (p. 23). Further elaboration on those 'therapeutic' activities would have been helpful.

McGarvey (1998) in a qualitative study explored the role of the nurse using a case study approach to examine nursing practice in the operating departments of three hospitals. Data were collected by observing of 358 hours of nursing practice, interviews with 35 nurses of

differing grades, and document analysis of the nursing care plans of 230 patients undergoing surgery. The study did not examine expressly as to how nurses defined their role, but did indicate that many nurses had difficulty in describing it and tended to view their role in terms of a set of functions they performed daily, rather than an overriding philosophy of care.

To further understand nursing in relation to surgery it is thus worth exploring the perioperative role from the temporal orientations set out by the preoperative, intraoperative and postoperative phases of nursing care.

The preoperative role

The preoperative phase commences as soon as the decision for surgical intervention is made and ends with the induction of anaesthesia (AORN 1985, Atkinson 1992). It can be as far-reaching as an initial assessment of the patient in the outpatient clinic or at home, or as short-term as an immediate preoperative patient assessment within the operating department. Nursing in the preoperative period is concerned primarily with the preparation of the patient for surgery from both a physical and psychological perspective. Specific patient-related activities include identifying and checking of patient details and safe positioning of the patient for their particular operation, while other activities include preparing equipment and instruments (Groah 1983, Kaczmarowski 1987, Atkinson 1992, Kneedler & Dodge 1991).

Recognition of the importance of the psychological preparation of the patient has increased substantially in the last 20 years, probably because of two main factors. First is the increasing emphasis on research-based practice. Research has highlighted the significant and beneficial variations in aspects of patient well-being and recovery between those who have had a structured preoperative education programme, and those who have not. Such variables have included postoperative infection, pain and recovery (Hayward 1977, Boore 1978, O'Sullivan & Richardson 1991, Martin 1996).

Second, the increasing support for patient consent and information about treatment has meant that the psychological aspect of patient preparation has come to the forefront of care. Publications, like 'A Charter for Patients and Clients' (Northern Ireland Health and Personal Social Services 1992), have indicated to individual patients that they should:

> ...be given clear information about any treatment or care proposed, including any risks and any alternatives, and to have your own wishes taken into account as far as possible (p. 3).

This involvement of surgical patients in their treatment and care can only be achieved if interactions between medical and nursing personnel and patients commence during this vital preoperative phase of their operating department experience.

The intraoperative role

The intraoperative period runs from the time the patient is transferred to the operating table to the time they are admitted to the recovery area (AORN 1985, Atkinson 1992). For a major proportion of this time, the patient is positioned on the operating table, undergoing a specified surgical or investigative procedure. Nursing responsibilities revolve primarily around maintaining the overall safety and dignity of the patient at such a crucial time. Typically this includes monitoring the patient's physical status, ensuring the safe use of surgical equipment, monitoring the sterile field, and carrying out safety checks associated with use of equipment and swabs. In some cases, the anaesthetic may be regional and so the patient may be fully conscious or under sedation. The nurse also has responsibilities toward the patient in terms of offering information and reassurance, in addition to ensuring continued comfort and physiological monitoring (Groah 1983, Kaczmarowski 1987, Kneedler & Dodge 1991, Atkinson 1992).

The postoperative role

The postoperative phase begins with the admission of the patient to the recovery area and ends when the surgeon discontinues follow-up care (AORN 1985, Atkinson 1992). The range of nursing activities includes at a basic level, passing information about the patient's surgery to the appropriate personnel in the recovery area, but potentially could extend to a postoperative evaluation in the ward, clinic or even the patient's home.

Essentially the postoperative role relates to ensuring that the patient has a safe recovery from anaesthesia and surgery. The nurse's responsibilities in relation to patient care include: correct positioning of the patient; maintaining the airway; monitoring respiratory function, circulation and other significant physiological signs; ensuring adequate fluid balance; administering analgesics and other medications; and giving information and reassurance about the surgery as required. In the extended postoperative period the role includes responsibilities toward mobilization and patient re-education (Groah 1983, Kaczmarowski 1987, Kneedler & Dodge 1991, Atkinson 1992, Fairchild 1996). However, whether these are functions really appropriate to the focused role of the operating department nurse is open to question.

Nursing skills in the postoperative period are of paramount importance to the overall care of the patient. At this critical time the condition of a patient can change suddenly and dramatically, and an urgent response is required. Therefore, while patient care still falls into two domains, the physiological and the psychological, it is in the immediate postoperative period that the physiological aspect of operating department nursing assumes greater significance. Communication between operating department nurses and recovery nurses is of paramount

importance to the continued care of the patient (Kneedler & Dodge 1991, Atkinson 1992, Fairchild 1996).

NEW OPERATING DEPARTMENT ROLES

As the use of technology within health care continues to advance, the operating department is a central location within the hospital for such change. As a result of these technological advances, new roles and practices have developed for operating department nurses (Hind 1997, McCreanor & Woods 1997, Brennan 1999). Such moves have implications not only for the future of nursing but for others, including the medical profession and patients.

Assistants during surgery

It has long been recognized that nurses have acted as assistants to the surgeon, either in the capacity of first assistant where the nurse provides skilled assistance but not surgical intervention, or as surgeon's assistant where the nurse actually engages in the process of surgery and undertakes a caseload under the supervision of medical staff (NATN 1993, 1994, Bernthal 1999). The need for such roles has arisen for a variety of reasons:

- the decreased availability of medical staff to assist during surgery both in scheduled sessions and during out of hours surgery;
- procedures that restrict access for other personnel, and not least;
- the desire of many nurses to advance their role and undertake different activities.

Various surgeons' assistants roles currently exist in this context (Royal College of Surgeons of England 1999), for example:

- cardiac surgeon's assistant;
- endoscopic nurses;
- laparoscopic nurses;
- orthopaedic surgeon's assistant;

as well as roles in other specialist areas, such as accident and emergency departments.

Preliminary evidence suggests that outcomes from such innovations may be favourable (Patrick *et al.* 1996, Langasco 1999), however, they also raise a number of issues in relation to training, status, authority and working relationships (English 1997). As a result, the Royal College of Surgeons has suggested that when such roles are to be developed:

- delegation must be achieved without exposing the patient to unnecessary risks;
- the patient must be aware of the role of the person treating them, and;
- surgeons' assistants must work to clearly laid down protocols.

Nurse anaesthetists

A few countries, most notably the USA and Scandinavia have endorsed the use of nurses for administering anaesthesics to surgical patients although this has not been endorsed in the UK. Indeed evidence suggests that American doctors are not necessarily in support of this role for nurses (Clabby 1998). In the UK, a multidisciplinary Scoping Study was carried out by the NHS executive (1996) to identify current anaesthetic practice and to make recommendations for the future. While the team was strongly opposed to the idea of nurse anaesthetists, there was widespread support for the development of an anaesthetic assistant role whether it be a nurse or an operating department assistant. Thus, the development of such a role is likely in the future.

CONCLUSIONS

This paper has considered the historical development of operating department nursing to the current day. However, concerns are raised that unless the role of the nurse in the operating department is further clarified and examined, it presents only a tenuous basis for future role development. In the UK, role definition of operating department nursing is patchy and research into the nursing practice is scant. Studies are small and have not addressed issues of role definition and development directly. In recent years, despite the changes in nurse education and the drive for evidence-based practice, this situation has not improved, yet the operating department is promoted as an exciting environment within which to work (Department of Health 1997). As a result, there is a real danger that role development will occur in line with the overriding pressures from hospital management, technology and the medical profession, instead of in line with the needs of patients and the fundamental principles of nursing.

It is imperative that operating department nurses engage collaboratively in a comprehensive and rigorous programme of research that examines their practice so that they can determine where their contribution to care is best made in the future. Such research must include:

- further exploration of the perioperative role to develop a theoretical base for nursing practice;
- ascertaining those nursing activities that are of benefit to surgical patients and those that are not;
- determining the outcome from new role developments.

Nurses must start to build a future for their professional practice that is built on sound theoretical principles rather than on just historical legacy alone.

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Standards for the Administration of Medicines

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

October 1992

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Introduction

1 This standards paper replaces the Council's advisory paper 'Administration of Medicines' (issued in 1986) (1) and the supplementary circular 'The Administration of Medicines' (PC 88/05) (2). The Council has prepared this paper to assist practitioners to fulfil the expectations which it has of them, to serve more effectively the interests of patients and clients and to maintain and enhance standards of practice.

2 The administration of medicines is an important aspect of the professional practice of persons whose names are on the Council's register. It is not solely a mechanistic task to be performed in strict compliance with the written prescription of a medical practitioner. It requires thought and the exercise of professional judgement which is directed to:

2.1 confirming the correctness of the prescription;

2.2 judging the suitability of administration at the scheduled time of administration;

2.3 reinforcing the positive effect of the treatment;

2.4 enhancing the understanding of patients in respect of their prescribed medication and the avoidance of misuse of these and other medicines and

2.5 assisting in assessing the efficacy of medicines and the identification of side effects and interactions.

3 To meet the standards set out in this paper is to honour, in this aspect of practice, the Council's expectation (set out in the Council's 'Code of Professional Conduct') (3) 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;

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;"

4 This extract from the 'Code of Professional Conduct' applies to all persons on the Council's register irrespective of the part of the register on which their name appears. Although the content of pre-registration education programmes varies, dependent on the part and level of the register involved, the Council expects that, in this area of practice as in all others, all practitioners will have taken steps to develop their knowledge and

competence and will have been assisted to this end. The word 'practitioner' is, therefore, used in the remainder of this paper to refer to all registered nurses, midwives and health visitors, each of whom must recognise the personal professional accountability which they bear for their actions. The Council therefore imposes no arbitrary boundaries between the role of the first level and second level registered practitioner in this respect.

Treatment with Medicines

5 The treatment of a patient with medicines for therapeutic, diagnostic or preventative purposes is a process which involves prescribing, dispensing, administering, receiving and recording. The word 'patient' is used for convenience, but implies not only a patient in a hospital or nursing home, but also a resident of a residential home, a client in her or his own home or in a community home, a person attending a clinic or a general practitioner's surgery and an employee attending a workplace occupational health department. 'Patient' refers to the person receiving a prescribed medicine. Each medicine has a product licence, which means that authority has been given to a manufacturer to market a particular product for administration in a particular dosage range and by specified routes.

Prescription

6 The practitioner administering a medicine against a prescription written by a registered medical

any medicines, in assisting with administration or overseeing any self-administration of medicines, exercise professional judgement and apply knowledge and skill to the situation that pertains at the time.

9 This means that, as a matter of basic principle, whether administering a medicine, assisting in its administration or overseeing self-administration, the practitioner will be satisfied that she or he:

9.1 has an understanding of substances used for therapeutic purposes;

9.2 is able to justify any actions taken and

9.3 is prepared to be accountable for the action taken.

10 Against this background, the practitioner, acting in the interests of the patients, will:

10.1 be certain of the identity of the patient to whom the medicine is to be administered;

10.2 ensure that she or he is aware of the patient's current assessment and planned programme of care;

10.3 pay due regard to the environment in which that care is being given;

10.4 scrutinise carefully, in the interests of safety, the prescription, where available, and the information provided on the relevant containers;

10.5 question the medical practitioner or pharmacist, as appropriate, if the prescription

or container information is illegible, unclear, ambiguous or incomplete or where it is believed that the dosage or route of administration falls outside the product licence for the particular substance and, where believed necessary, refuse to administer the prescribed substance;

10.6 refuse to prepare substances for injection in advance of their immediate use and refuse to administer a medicine not placed in a container or drawn into a syringe by her or him, in her or his presence, or prepared by a pharmacist, except in the specific circumstances described in paragraph 40 of this paper and others where similar issues arise and

10.7 draw the attention of patients, as appropriate, to patient information leaflets concerning their prescribed medicines.

11 In addition, acting in the interests of the patient, the practitioner will:

11.1 check the expiry date of any medicine, if on the container;

11.2 carefully consider the dosage, method of administration, route and timing of administration in the context of the condition of the specific patient at the operative time;

11.3 carefully consider whether any of the prescribed medicines will or may dangerously interact with each other;

11.4 determine whether it is necessary or advisable to withhold the medicine pending consultation with the prescribing medical practitioner, the pharmacist or a fellow professional colleague;

11.5 contact the prescriber without delay where contra-indications to the administration of any prescribed medicine are observed, first taking the advice of the pharmacist where considered appropriate;

11.6 make clear, accurate and contemporaneous record of the administration of all medicines administered or deliberately withheld, ensuring that any written entries and the signature are clear and legible;

11.7 where a medicine is refused by the patient, or the parent refuses to administer or allow administration of that medicine, make a clear and accurate record of the fact without delay, consider whether the refusal of that medicine compromises the patient's condition or the effect of other medicines, assess the situation and contact the prescriber;

11.8 use the opportunity which administration of a medicine provides for emphasising, to patients and their carers, the importance and implications of the prescribed treatment and for enhancing their understanding of its effects and side-effects;

11.9 record the positive and negative effects of the medicine and make them known to the prescribing medical practitioner and the pharmacist and

11.10 take all possible steps to ensure that replaced prescription entries are correctly deleted to avoid duplication of medicines.

Applying the Standards in a Range of Settings

Who can administer medicines?

12 There is a wide spectrum of situations in which medicines are administered ranging, at one extreme, from the patient in an intensive therapy unit who is totally dependent on registered professional staff for her or his care to, at the other extreme, the person in her or his own home administering her or his own medicines or being assisted in this respect by a relative or another person. The answer to the question of who can administer a medicine must largely depend on where within that spectrum the recipient of the medicines lies.

Administration in the hospital setting

13 It is the Council's position that, at or near the first stated end of that spectrum, assessment of response to treatment and speedy recognition of contra-indications and side-effects are of great importance. Therefore prescribed medicines should only be administered by registered practitioners who are competent for the purpose and aware of their personal accountability.

practitioner, like the pharmacist responsible for dispensing it, can reasonably expect that the prescription satisfies the following criteria:

6.1 that it is based, whenever possible, on the patient's awareness of the purpose of the treatment and consent (commonly implicit);

6.2 that the prescription is either clearly written, typed or computer-generated, and that the entry is indelible and dated;

6.3 that, where the new prescription replaces an earlier prescription, the latter has been cancelled clearly and the cancellation signed and dated by an authorised registered medical practitioner;

6.4 that, where a prescribed substance (which replaces an earlier prescription) has been provided for a person residing at home or in a residential care home and who is dependent on others to assist with the administration, information about the change has been properly communicated;

6.5 that the prescription provides clear and unequivocal identification of the patient for whom the medicine is intended;

6.6 that the substance to be administered is clearly specified and, where appropriate, its form (for example tablet, capsule, suppository) stated, together with the strength,

dosage, timing and frequency of administration and route of administration;

6.7 that, where the prescription is provided in an out-patients or community setting, it states the duration of the course before review;

6.8 that, in the case of controlled drugs, the dosage is written, together with the number of dosage units or total course if in an out-patient or community setting, the whole being in the prescriber's own handwriting;

6.9 that all other prescriptions will, as a minimum, have been signed by the prescribing doctor and dated;

6.10 that the registered medical practitioner understands that the administration of medicines on verbal instructions, whether she or he is present or absent, other than in exceptional circumstances, is not acceptable unless covered by the protocol method referred to in paragraph 6.11;

6.11 that it is understood that, unless provided for in a specific protocol, instruction by telephone to a practitioner to administer a previously unprescribed substance is not acceptable, the use of facsimile transmission (fax) being the preferred method in exceptional circumstances or isolated locations and

6.12 that, where it is the wish of the professional staff concerned that practitioners in a particular setting be authorised to administer, on their own authority, certain medicines, a local protocol has been agreed between medical practitioners, nurses and midwives and the pharmacist.

Dispensing

7 The practitioner administering a medicine dispensed by a pharmacist in response to a medical prescription can reasonably expect that:

7.1 the pharmacist has checked that the prescription is written correctly so as to avoid misunderstanding or error and is signed by an authorised prescriber;

7.2 the pharmacist is satisfied that any newly-prescribed medicines will not dangerously interact with or nullify each other;

7.3 the pharmacist has provided the medicine in a form relevant for administration to the particular patient, provided it in an appropriate container giving the relevant information and advised appropriately on storage and security conditions;

7.4 where the substance is prescribed in a dose or to be administered by a route which falls outside its product licence, unless to be administered from a stock supply, the pharmacist

will have taken steps to ensure that the prescriber is aware and has chosen to exceed that licence;

7.5 where the prescription for a specific item falls outside the terms of the product licence, whether as to its route of administration, the dosage or some other key factor, the pharmacist will have ensured that the prescriber is aware of this fact and, mindful of her or his accountability in the matter, has made a record on the prescription to this effect and has agreed to dispense the medicine ordered;

7.6 if the prescription bears any written amendments made and signed by the pharmacist, the prescriber has been consulted and advised and the amendments have been accepted and

7.7 the pharmacist, in pursuit of her or his role in monitoring the adverse side-effects of medicines, wishes to be sent any information that the administering practitioner deems relevant.

Standards for the Administration of Medicines

8 Notwithstanding the expected adherence by registered medical practitioners and pharmacists to the criteria set out in paragraphs 6 and 7 of this paper, the nurse, midwife or health visitor must, in administering

25.1 satisfy the requirements of the Royal Pharmaceutical Society of Great Britain for an original container;

25.2 be filled by a pharmacist and sealed by her or him or under her or his control and delivered complete to the user;

25.3 be accompanied by clear and comprehensive documentation which forms the medical practitioner's prescription;

25.4 bear the means of identifying tablets of similar appearance so that, should it be necessary to withhold one tablet (for example Digoxin), it can be identified from those in the container space for the particular time and day;

25.5 be able to be stored in a secure place and

25.6 make it apparent if the containers (be they blister packs or spaces within a container) have been tampered with between the closure and sealing by the pharmacist and the time of administration.

26 While the introduction of a monitored dosage system transfers to the pharmacist the responsibility for being satisfied that the container is filled and sealed correctly so as to comply with the prescription, it does not alter the fact that the practitioner administering the medicines must still consider the appropriateness of each medicine at the time administration falls due. It is not the case, therefore, that the use of a

monitored dosage system allows the administration of medicines to be undertaken by unqualified personnel.

27 It is not acceptable, in lieu of a pharmacist-filled monitored dosage system container, for a practitioner to transfer medicines from their original containers into an unsealed container for administration at a later stage by another person, whether or not that person is a registered practitioner. This is an unsafe practice which carries risks for both practitioner and patient. Similarly it is not acceptable to interfere with a sealed section at any time between its closure by the pharmacist and the scheduled time of administration.

The role of nurses, midwives and health visitors in community practice in the administration of medicines

28 Any practitioner who, whether as a planned intervention or incidentally, becomes involved in administering a medicine, or assisting with or overseeing such administration, must apply paragraphs 8 to 11 of this paper to the degree to which they are relevant.

29 Where a practitioner working in the community becomes involved in obtaining prescribed medicines for patients, she or he must recognise her or his responsibility for safe transit and correct delivery.

30 Community psychiatric nurses whose practice involves them in providing assistance to patients to reduce and eliminate their dependence on addictive drugs should ensure that they are aware of the potential value of short term prescriptions and

encourage their use where appropriate in the long term interests of their clients. They must not resort to holding or carrying prescribed controlled drugs to avoid their misuse by those clients.

31 Special arrangements and certain exemptions apply to occupational health nurses. These are described in Information Document 11 and the Appendices of 'A Guide to an Occupational Health Nursing Service; A Handbook for Employers and Nurses'; published by the Royal College of Nursing (4).

32 Some practitioners employed in the community, including in particular community nurses, practice nurses and health visitors, in order to enhance disease prevention, will receive requests to participate in vaccination and immunisation programmes. Normally these requests will be accompanied by specific named prescriptions or be covered by a protocol setting out the arrangements within which substances can be administered to certain categories of persons who meet the stated criteria. The facility provided by the 'Medicines Act 1968' (5) for substances to be administered to a number of people in response to an advance 'direction' is valuable in this respect. Where it has not been possible to anticipate the possible need for preventive treatment and there is no relevant protocol or advance direction, particularly in respect of patients about to travel abroad and requiring preventive treatment, a telephone conversation with a registered medical practitioner

will suffice as authorisation for a single administration. It is not, however, sufficient as a basis for supplying a quantity of medicines.

Midwives and Midwifery Practice

33 Midwives should refer to the current editions of both the Council's 'Midwives Rules' (6) and 'A Midwife's Code of Practice' (7), and specifically to the sections concerning administration of medicines. At the time of publication of this paper, 'Midwives Rules' sets out the practising midwife's responsibility in respect of the administration of medicines and other forms of pain relief. 'A Midwife's Code of Practice' refers to the authority provided by the 'Medicines Act 1968' and the 'Misuse of Drugs Act 1971'(8), and regulations made as a result, for midwives to obtain and administer certain substances.

What if the Council's standards in paragraphs 8 to 11 cannot be applied?

34 There are certain situations in which practitioners are involved in the administration of medicines where some of the criteria stated above either cannot be applied or, if applied, would introduce dangerous delay with consequent risk to patients. These will include occupational health settings in some industries, small hospitals with no resident medical staff and possibly some specialist units within larger hospitals and some community settings.

14 In this context it is the Council's position that, in the majority of circumstances, a first level registered nurse, a midwife, or a second level nurse, each of whom has demonstrated the necessary knowledge and competence, should be able to administer medicines without involving a second person. Exceptions to this might be:

14.1 where the practitioner is instructing a student;

14.2 where the patient's condition makes it necessary and

14.3 where local circumstances make the involvement of two persons desirable in the interests of the patients (for example, in areas of specialist care, such as a paediatric unit without sufficient specialist paediatric nurses or in other acute units dependent on temporary agency or other locum staff).

15 In respect of the administration of intravenous drugs by practitioners, it is the Council's position that this is acceptable, provided that, as in all other aspects of practice, the practitioner is satisfied with her or his competence and mindful of her or his personal accountability.

16 The Council is opposed to the involvement of persons who are not registered practitioners in the administration of medicines in acute care settings and with ill or dependent patients, since the requirements of paragraphs 8 to 11 inclusive of this paper cannot then be

satisfied. It accepts, however, that the professional judgement of an individual practitioner should be used to identify those situations in which informal carers might be instructed and prepared to accept a delegated responsibility in this respect.

Administration in the domestic or quasi-domestic setting

17 It is evident that in this setting, on the majority of occasions, there is no involvement of registered practitioners. Where a practitioner engaged in community practice does become involved in assisting with or overseeing administration, then she or he must observe paragraphs 8 to 11 of this paper and apply them to the required degree. She or he must also recognise that, even if not employed in posts requiring registration with the Council, she or he remains accountable to the Council.

18 The same principles apply where prescribed medicines are being administered to residents in small community homes or in residential care homes. To the maximum degree possible, though related to their ability to manage the care and administration of their prescribed medicines and comprehend their significance, the residents should be regarded as if in their own home. Where assistance is required, the person providing it fills the role of an informal carer, family member or friend. However, as with the situation described in paragraph 17, where a professional practitioner is involved,

a personal accountability is borne. The advice of a community pharmacist should be sought when necessary.

Self-administration of medicines in hospitals or registered nursing homes

19 The Council welcomes and supports the development of self-administration of medicines and administration by parents to children wherever it is appropriate and the necessary security and storage arrangements are available.

20 For the hospital patient approaching discharge, but who will continue on a prescribed medicines regime following the return home, there are obvious benefits in adjusting to the responsibility of self-administration while still having access to professional support. It is accepted that, to facilitate this transition, practitioners may assist patients to administer their medicines safely by preparing a form of medication card containing information transcribed from other sources.

21 For the long stay patient, whether in hospital or a nursing home, self-administration can help foster a feeling of independence and control in one aspect of life.

22 It is essential, however, that where self-administration is introduced for all or some patients, arrangements must be in place for the appropriate, safe and secure storage of the medicines, access to which is limited to the specific patient.

The use of monitored dosage systems

23 Monitored dosage systems, for the purpose of this paper, are systems which involve a community pharmacist, in response to the full prescription of medicines for a specific person, dispensing those medicines into a special container with sections for days of the week and times within those days and delivering the container, or supplying the medicines in a special container of blister packs, with appropriate additional information, to the nursing home, residential care home or domestic residence. The Council is aware of the development of such monitored dosage systems and accepts that, provided they are able to satisfy strict criteria established by the Royal Pharmaceutical Society of Great Britain and other official pharmaceutical organisations, that substances which react to each other are not supplied in this way and that they are suitable for the intended purpose as judged by the nursing profession, they have a valuable place in the administration of medicines.

24 While, to the present, their use has been primarily in registered nursing homes and some community or residential care homes, there seems no reason why, provided the systems can satisfy the standards referred to in paragraph 25, their use should not be extended.

25 In order to be acceptable for use in hospitals or registered nursing homes, the containers for the medicines must:

35 With the exception of the administration of substances for the purpose of vaccination or immunisation described in paragraph 32 above, in any situation in which a practitioner may be expected or required to administer 'prescription-only medicines' which have not been directly prescribed for a named patient by a registered medical practitioner who has examined the patient and made a diagnosis, it is essential that a clear local policy be determined and made known to all practitioners involved with prescribing and administration. This will make it possible for action to be taken in patients' interests while protecting practitioners from the risk of complaint which might otherwise jeopardise their position.

36 Therefore, where such a situation will, or may apply, a local policy should be agreed and documented which:

36.1 states the circumstances in which particular 'prescription-only medicines' may be administered in advance of examination by a doctor;

36.2 ensures the relevant knowledge and skill of those to be involved in administration;

36.3 describes the form, route and dosage range of the medicines so authorised and

36.4 wherever possible, satisfies the requirements of Section 58 of the 'Medicines Act 1968' as a 'direction'.

Substances for topical application

37 The standards set out in this paper apply, to the degree to which they are relevant, to substances used for wound dressing and other topical applications. Where a practitioner uses a substance or product which has not been prescribed, she or he must have considered the matter sufficiently to be able to justify its use in the particular circumstances.

The administration of homoeopathic or herbal substances

38 Homoeopathic and herbal medicines are subject to the licensing provisions of the 'Medicines Act 1968', although those on the market when that Act became operative (which means most of those now available) received product licenses without any evaluation of their efficacy, safety or quality. Practitioners should, therefore, make themselves generally aware of common substances used in their particular area of practice. It is necessary to respect the right of individuals to administer to themselves, or to request a practitioner to assist in the administration of substances in these categories. If, when faced with a patient or client whose desire to receive medicines of this kind appears to create potential difficulties, or if it is felt that the substances might either be an inappropriate response to the presenting symptoms or likely to negate or enhance the effect of prescribed medicines, the

practitioner, acting in the interests of the patient or client, should consider contacting the relevant registered medical practitioner, but must also be mindful of the need not to override the patient's rights.

Complementary and alternative therapies

39 Some registered nurses, midwives and health visitors, having first undertaken successfully a training in complementary or alternative therapy which involves the use of substances such as essential oils, apply their specialist knowledge and skill in their practice. It is essential that practice in these respects, as in all others, is based upon sound principles, available knowledge and skill. The importance of consent to the use of such treatment must be recognised. So, too, must the practitioner's personal accountability for her or his professional practice.

Practitioners assuming responsibility for care which includes medicines being administered which were previously checked by other practitioners

40 Paragraph 10.6 of this paper referred to the unacceptability of a practitioner administering a substance drawn into a syringe or container by another practitioner when the practitioner taking over responsibility for the patient was not present. An exception to this is an already established intravenous

infusion, the use of a syringe pump or some other kind of continuous or intermittent infusion or injection apparatus, where a valid prescription exists, a responsible practitioner has signed for the container of fluid and any additives being administered and the container is clearly and indelibly labelled. The label must clearly show the contents and be signed and dated. The same measures must apply equally to other means of administration of such substances through, for example, central venous, arterial or epidural lines. Strict discipline must be applied to the recording of any substances being administered by any of the methods referred to in this paragraph and to reporting procedures between staff as they change and transfer responsibility for care.

Management of errors or incidents in the administration of medicines

41 In a number of its Annual Reports, the Council has recorded its concern that practitioners who have made mistakes under pressure of work, and have been honest and open about those mistakes to their senior staff, appear often to have been made the subject of disciplinary action in a way which seems likely to discourage the reporting of incidents and therefore be to the potential detriment of patients and of standards.

42 When considering allegations of misconduct arising out of errors in the administration of medicines, the Council's Professional Conduct

Committee takes great care to distinguish between those cases where the error was the result of reckless practice and was concealed and those which resulted from serious pressure of work and where there was immediate, honest disclosure in the patient's interest. The Council recognises the prerogative of managers to take local disciplinary action where it is considered to be appropriate but urges that they also consider each incident in its particular context and similarly discriminate between the two categories described.

43 The Council's position is that all errors and incidents require a thorough and careful investigation which takes full account of the circumstances and context of the event and the position of the practitioner involved. Events of this kind call equally for sensitive management and a comprehensive assessment of all of the circumstances before a professional and managerial decision is reached on the appropriate way to proceed.

Future arrangements for prescribing by nurses

44 In March 1992 the Act of Parliament entitled the 'Medicinal Products: Prescription by Nurses etc Act 1992' (9) became law. This legislation is to come into operation in October 1993. The legislation will permit nurses with a district nursing or health visiting qualification to prescribe certain products from a Nurse Prescribers' Formulary. The statutory

rules, yet to be completed, will specify the categories of nurses who can prescribe under this limited legislation. The Council will issue further information concerning this important new legislation prior to it becoming operative.

45 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

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