28th june 2013 Witness Statement Ref. No. 329/1

NAME OF CHILD: Raychel Ferguson

Name: Anne Witherow

Title: Mrs.

Present position and institution: Assistant Director of Nursing

WHSCT

Previous position and institution:

Tissue Viability Nurse Specialist /Clinical Effectiveness Co-ordinator

Membership of Advisory Panels and Committees:

2007 to date Trust Medication Governance Committee
2009 to date Risk Management Committee
2009 to date Quality and Standards Committee
2009 to date Trust Governance Committee
2008 to date Trust Nursing and Midwifery Governance
2008 to date Environmental Cleanliness Steering Group
2010 to date Lead Nurse accountability meeting – nursing key performance indicators
2012 to date Trust record keeping steering group
2010 to date Regional Record Keeping Group
2009 to date Clinical Audit Group
2011 to date Acute Services Directorate Governance group
2012 to date Patient Client Experience Steering group
2009 to date Primary Care and Older people Governance Meeting
2012 to date Regional Nursing Key Performance Indicators
2012 to date Regional Patient Safety Falls and Skin Bundle Group
2009 to date Trust Patient Safety and Quality Steering Group
2008 to date Regional Patient and Client Experience group
2010 to date Resuscitation Committee
2012 to date Medication Safety Group

Pre 2007
Altnagelvin Risk Management and Standards Committee 2003 to 2005
Trust Clinical Incident Review Meeting 2003
Clinical Audit Committee 2001 to date
European Pressure Ulcer Panel 2001 – 2006
Regional Dressing Project 2003-200
Tissue Viability Network 2000 – 2007
All Ireland Wound Management Association 2000-2007

Previous Statements, Depositions and Reports: **None**
OFFICIAL USE: **List of previous statements, depositions and reports attached:**

Ref:	**Date:**	

IIMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

(1) Please provide the following information:

(a) Your qualifications as of 2001 (please also provide a copy of your CV);

RGN 1977

Diploma Health Care Studies

PGD Diploma Tissue Regeneration and Repair

CV attached appendix 1

(b) Describe your career history up until June 2001 at the AHHSST (identifying your position in the AHHSST as at June 2001);

In 2001 I was employed at WHHSST as the Tissue Viability Nurse Specialist with additional role of Clinical Effectiveness Co-ordinator

(c) Was there a written job description for your post in 2001? If so please provide copy of the same. If not, what were the functions, accountabilities and responsibilities of the post?

I have not been able to access my previous job description

The main duties of my job in 2001 were split between specialist nurse tissue viability and clinical effectiveness co-ordinator

- **Responsibility for assuring the Trust that the standard of care given within Tissue Viability service reflects the best available evidence from research, NICE type guidance and the standards within the regional wound care formulary.**
- **Participate in regional Tissue Viability work and in particular bed contracts and wound care products**
- **Line Management responsibility for the Clinical Audit Department**
- **Support staff in matter of clinical effectiveness as required**

(2)

(a) The nursing structures in place in 2001, including lines of accountability/responsibility of clinical service managers, ward managers, senior nurses, ward nurses etc. outlining the

principal functions of each post;

Please see appendix 2 structure diagram

I am not able to access Job Descriptions of ward sisters and ward nurses for 2001

The key role of a ward sister was

- To ensure the delivery of safe and effective patient care
- Develop systems to ensure all staff are live on the UKCC register
- To manage resources effectively and efficiently including staff rotas and leave entitlement to reflect the needs of the patients across the 24 hour period
- To ensure staff appraisal is undertaken in line with Trust Policy
- Identity training and development needs of staff and develop a plan to ensure delivery of same
- Participate in the hospital bleep rota

To ensure staff adhered to Trust Policies and Guidance

(b) **The nature and frequency of meetings with nursing staff (and were such meetings minuted);**

In 2001 I held educational meetings with ward sisters and wound link staff nurses in relation to the tissue viability aspect of my role which included running education sessions and wound link nurse meetings. These meetings were noted but I am unable to provide the minutes of these events. They were held quarterly meetings from my recall.

(c) **Whether nursing-related committees and groups were in place in 2001, and whether the meetings of such committees and groups were minuted? What part, if any, did you play in these committees/groups?**

I attended meetings led by the Director of Nursing and Clinical Services Managers on an ad hoc basis when there was a particular item on the agenda for me to address. These would, from memory, have included ward sisters meeting and clinical effectiveness matters. I do not have access to any records of these meetings.

I also have a recollection of attending meetings related to quality improvement initiatives for nursing care such as HOSQIP (Standard setting etc) and advanced nursing practice meetings but cannot access minutes of these events.

Clinical Incident Review Meeting

(3) Had the AHHSST adopted the concept of family-centred care in 2001, and if so, what training was given in this regard?

Family- centred care was an integral part of the undergraduate and post graduate training programmes for paediatric registration.

Ward 6 philosophy of care embraced the value of family centred care highlighting the uniqueness of each child. Open visiting was encouraged and parental involvement in the child's care was to be actively encouraged. This also included the provision of a parent's information booklet. Play therapists were an integral part of the workforce on ward 6 with the remit of providing a stimulating environment.

Corporate support for family centred care was evidenced by the development of family facilities such as a parents kitchen and the ability to remain overnight on the ward.

An audit on preoperative fasting times in elective paediatric surgery was also conducted during 2001 based on the Royal College of Anaesthetic Standards

A general audit of the both staff and parents knowledge and use of these facilities was carried out quarterly during July 98- September 1999 which provided valuable information and helped staff make improvements to the care environment.

An in-patient snap shot survey was undertaken during 2000 across a range of specialities which included surveying the perception of various aspects of non clinical care.

(4) From a 2001 perspective, please detail:

(a) The composition of a Children's Ward nursing team and the minimum staffing requirements thereof;

This is not work that fell within my remit so I cannot comment

(b) **Whether any difficulty was experienced in achieving full deployment of nurses on duty in Ward 6 at any time in June 2001;**

This is not information that would have been part of my work.

(c) Whether at any time during Raychel's stay in hospital the nursing workforce complement fell below a level consonant with RCN Guidance on staffing Children's Wards;

Not that I was aware of.

(d) Whether there were at least two Registered Sick Children's Nurses on duty at all times in Ward 6 between 7th and 9th June 2001;

A review of the off duty rotas for the 6th and 7th june would indicate there were at least two RSCN staff nurses on duty

(e) **The steps taken to maintain and monitor parent's satisfaction with the care delivered in Ward 6 in accordance with the *"Nursing Philosophy"* (Ref: 316-023-004);**

MONITOR, a nationally developed quality assurance tool and endorsed by the Department of Health as the tool for use in determining the quality of care was in use as part of the nursing quality improvement programme.

The regional approach to the implementation of monitor included some use of peer review.

Peer review was on-going between the then Sperrin Lakeland and Altnagelvin Trust

However, the report indicates ward 6 was not included in the peer review process.

Junior MONITOR applicable for paediatric areas, had been used to assess the standards and quality of paediatric care during 2000. The Monitor tool reviews 7 key aspects of care. This included discussions with parents and family regarding their satisfaction with the care provided and examined the contribution made by parents in relation to the assessment of need and plan of care. Both of these aspects of care are core to the ward 6 philosophy . Please see attached report.

(f) **The programme of post-registration professional development, supervision and appraisal in place for nursing staff;**

In 2001 in line with AHHSST performance review programme staff were undergoing appraisals / individual performance reviews annually. This led to staff learning and development needs being identified. This system was also designed to identify poor or underperformance in individual nurses and support the development of a learning and development plan and an opportunity to improve before considering any disciplinary action

From my recall each division had a training budget which would have been used to access training which could not be accessed through Educare(the provider of post entry education department at that time) or through commissioned courses by the university.

On taking up post each new nurse would have been allocated a preceptor which by the UKCC guidance had to have completed the formal preceptor course and have one years' experience. This system is in line with the UKCC Guidance and Standards on preceptorship. It supported the development and safe practice of new appointed nursing staff in their first 4- 6 months.

Staff had to undertake training to prepare for the role of a mentor.

On taking up employment all staff members were subject to a probationary period as per

Job contracts.

There was a mandatory training programme in place which all staff were required to attend annually from my recall which included basic life support and CPR, moving and handling, Infection Control issues and legal aspects of documentation.

(5) **Those clinical protocols available to nurses in Ward 6?** I do not have a list of these

(6) **Please state what steps nurses were expected to take to maintain their knowledge and competence in line with the *"UKCC Code of Conduct"* and *"Scope of Professional Practice"* guidance in 2001? What training and assistance was in place to aid their continued professional development?**

In 2001 in line with the UKCC Code of Practice (appendix 3) it is the individual nurses personal responsibility to ensure they maintained and improved their professional knowledge and competence. This would have included accessing training and learning programmes to keep themselves up to date and fit for practice.

As described on point 4 there was a Trust approach to appraisal and learning and

development with a range of learning and development opportunities available.

Educare Care the in-service training body provided a wide range of training programmes.

In 2001 the Trust also invested in a link nurse system which was normally led by specialist nursing staff that had an education and training component to their role.

Staff nurses were encouraged to take a link nurse role and the training and development was supported by the ward manager in terms of off duty rosters. They were then expected to provide updates and information for their colleagues at ward level

In 2001 there were other opportunities for staff to attend additional learning and development courses were provided through the post entry and special leave process. A post entry committee reviewed applications from staff wishing to be seconded to attend University courses and or specialist courses by training bodies which were not available through the in-service programme.

(7) In respect of nursing matters:

(a) Was there a patient-specific nurse allocated to Raychel Ferguson;

I do not know if this was the case

(b) What was the role of the Ward Sister on Ward 6 in June 2001;

The role of a ward sister in June 201 would have been to provide leadership to nursing staff and ensure patient were cared for safely and in line with the available evidence and to manage resources within the ward

(c) Was there a Night Nurse covering Ward 6 in June 2001, and if so what was her role;

The hospital would have been managed at night by the Hospitals Service Manager whose role it was to coordinate and manage staff, patients and the environment at night and to respond to any concerns and requests for help from staff in all departments

All wards had a registered nurse – in- charge

(d) Was there a policy on nurse staffing levels for the Children's Ward;

This would not have been within my work remit so am unable to answer.

(e) How was assurance provided in respect of the knowledge, competence and suitability of nurses to work with children, and that nurses kept up to date with current practice;

Please refer to the answer provided in question 6

(f) Was there a system of independent external scrutiny in place to review nursing performance in the AHHSST, and if so please provide details of the same;

I am only aware of external reviews by the National Board and the Monitor review as per question 4 point E.

I am aware that a system of peer review did take place in a number of wards when monitor was being used - staff from Sperrin Lakeland Trust and Altnagelvin staff did cross over and review the others facilities but I cannot say if this happened with the ward 6 review

What mechanisms were there in place to monitor the quality of care delivered to children in 2001;

Additional to the use of monitor as detailed at question a number of other audits would have been carried out pre 2001 and post 2001. These include:

- Led on the Implementation of the regional guidance on managing medical devices 1999.
- Audit of staff and parents knowledge of supportive facilities 1999
- Multidisciplinary audit of patient records 1999
- Inpatient survey 2000
- Preoperative fasting in children April 2001
- Growth monitoring 2002
- Management of IV fluids 2002
- Re-audit of documentation ongoing 200/3
- Delayed union of treated by IM nailing in children 2002
- Management of croup 2003
- Prescribing in neo natal intensive care unit 2002-2003
- Dissatisfaction in children with hearing aids 2003
- In complete response to Speech therapy in hearing impaired children
- Sedation of children 2003
- Audit of patient identification bands including ward 6 2003

(g) Why was the use of the Episodic Care Plan discontinued?

The decision to discontinue the episodic care plan had to be taken as a result of the withdrawal of the technical support for the software from the company who developed the DM care plan system.

(8) Please outline the steps taken to *"ensure that nursing care adheres to the policies and procedures accepted with the Western Health & Social Services Board and also the Children's Act, European Charter and Action for Sick Children."* **(Ref: 316-023-005)? Please further identify those aspects of the policies and procedures thought relevant.**

Compliance with protocols and policies would have been part of the appraisal process. In

light of the absence of these policies being available I cannot make any further comment

(9) What guidance was provided to nursing staff, prior to June 2001, in respect of:

(a) The monitoring and recording of post-operative fluid balance;

The monitoring and recording of post- operative fluid balance would I believe have been be taught in the undergraduate nursing programme training programme.

As I have not been able to access a copy of the content of the Trust IV Fluid Training programme delivered through Educare I am unable to comment if this was included in this post entry training programme

(b) Recording weights in children;

From my recall at that time medications were calculated according to the weight of a patient – the role of the prescriber was to ensure this information was recorded on the patient's medicine kardex to allow drug dosages to be calculated accurately.

Nursing assessments would have included a weight for the child

Monitoring urea and electrolyte levels and electrolyte management in children;

Agreeing the frequency of monitoring and management of a patient's urea and electrolytes profile is a medical responsibility.

(c) The treatment of vomiting in children;

Prescribing treatment for a patient who is vomiting is the role and responsibility of the doctor

(d) The documentation of vomiting;

Any fluid loss including vomit should be accurately recorded on a patient's fluid balance charts to include type amount and frequency of loss

Caring for children with headaches and listlessness;

Management of a patient who complains of headaches and or listless should include a record of a range of vital signs.

Where the vital signs are out- with normal limits the nurse should raise with the nurse in charge and the doctor requesting a medical review. Analgesia as appropriate should be administered

Updating, amending and compiling nursing care plans/ episodic care plans;

This would have been included in the training provided by the Trust during implementation of DM nurse the computerised system.

Care planning would have been an integral component in the undergraduate nurse training programmes. In-service education provided sessions on record keeping including the legal aspects on record keeping.

(e) Communication with parents;

I am unaware of a specific Trust guidance on this.

Communication with parents would have been an integral component of the undergraduate training programme and is integral to the philosophy of ward 6 where communication with parents and family is highlighted as a key tenant of this philosophy.

(f) Recording communication with parents;

Training on record keeping should have included the requirement to record pertinent conversations with the parents and family members

Providing information to senior doctors and consultants in respect of patients and the documentation of the same;

Nursing staff are responsible to provide information about the patients in their care to doctors and a range of other appropriate health care professionals as appropriate to the care of the patient. Information provided that was pertinent to the care of the patient should have been documented in the nursing notes.

(g) Recording contact and attempts to contact junior doctors, and the information given to such doctors and advice received from them;

Where a nurse attempts to contact a medical staff members to raise concerns or check a treatment plan about a patient this should be recorded in the nursing notes and should include the doctor spoken to, date and time and the instructions or advice given

Where the doctor fails to respond to their bleep then this should be recorded and the next senior medical person contacted and requested to see the patient.

(h) The conduct of handovers;

Nursing handovers normally took place in a formal manner at the start and end of each shift and in the middle of the day with on-going exchanges of information during the 24 hour period as the patient's condition warranted.

The identification of senior doctors and consultants with individual responsibility for the patient;

My recall is elective admissions were admitted under the consultant they were attending and who organised their admission. Emergency admissions would have been allocated to the care of the consultant on call.

(i) The completion of patient records;
The Trust had a policy entitled 'Case Note Standards 1997' appendix 2
A training programme entitled Legal Aspects of Documentation was available for nursing staff through Educare. Record Keeping would have been part of the under graduate programme.

(a) Raising concerns about short comings in medical practice and patient treatment, and or whistle blowing;

Members of staff who had a concern about any health care professional practice would have been encouraged to raise this with their line manager who in turn should have taken the concerns forward and addressed these as appropriate.

(b) **Summoning the on-call team and the consultant;**

This would have been through the bleep system and or in some cases by direct contact.

There would have been an on call rota which should have been available for all staff to refer to.

Where a cardiac or respiratory arrest was suspected contact was through switch board to activate an automatic emergency response from the trusts cardiac arrest team.

(c) **Deciding when to refer children to an appropriate doctor;**

The decision to refer a child to a doctor was normally one based on clinical judgement for example where a patient was not responding to the care and treatment agreed and or where unexpected concerns arose.

(j) The investigation of nursing issues arising in a serious untoward incident such as the death of a patient following surgery?

The Trusts clinical incident investigation process would highlight not just nursing but any clinical concerns that might arise.

(10) In 2001, what arrangements did the AHHSST have in place to ensure that regular and systematic nursing/clinical audits took place? If such arrangements were in place please advise:

(a) Was there a Clinical Audit Committee? If so, what was its remit;

The Trust had a Clinical Audit Committee whose remit was to

Provide assurance that rigorous and robust systems were in place to support clinical audits

It was required to develop a clinical audit strategy in conjunction with directorates.

To advice on corporate /regional audits to be undertaken and agree Directorate audit plans.

To agree and provide support for audits as appropriate through the clinical audit team.

Raise any concerns there might be regarding audit findings

To organise and host the Trust Annual Clinical Audit Quality and Research symposium.

Responsible for the production of the Trusts Annual Clinical Audit, Quality and Research report.

(b) Did you play a role in the Clinical Audit Committee;

In 2001 I was member of the committee

(c) **Who served on the Clinical Audit Committee;**

A range of staff were on the audit committee; the clinical audit coordinator chaired the committee, representatives were sought from PAMS/ Risk Management/Drugs and Therapeutic committee/ HOSQIP/senior clinical audit assistant/secretary/

(d) **Who was responsible for ensuring that nursing/clinical audits were carried out;**

The clinical service managers and clinical leads.

(e) **To whom were the results of nursing/clinical audits sent;**

Staff were required to complete the section on the clinical audit form outlining who and where the audit results would be reported to

It was required that the line manager who commissioned the audit should initially be the first recipient of the findings of the audit prior to presentation to a wider forum

(f) **What action could be taken on foot of the results of nursing/clinical audits; action on the basis of the audit reports would be expected to be taken to ensure patient care was improved and a re-audit.**

The auditor would be required to provide a report detailing the audit findings and recommendations arising.

Action plans to address the recommendations would be the responsibility of the clinical teams providing the service and the clinical lead and service managers role to ensure this happened.

A re-audit would have been required to close the loop

As to specific systems for the audit of nursing practices or procedures;

(g) **As to whether there was any procedure or system in place in 2001 to audit the quality, clarity and completeness of clinical case notes?**

During 1999 and 2001 there had been a large multidisciplinary audit of nursing and medical records on-going. A re-audit was carried out in 2002/3

(11) **Please particularise all steps that you were aware of taken to investigate the care, treatment and death of Raychel Ferguson, and specify those steps taken by you.**

Following the death of Raychel My role in the investigations included attendance at a meeting with Dr Fulton and other staff and I was asked to

- discuss the record keeping with ward 6 staff in relation to fluid charts in particular
- to review the fluid balance chart and ascertain if it was adequate
- to link with Dr O'Kane about the potential of abnormal result being flagged up on the computerized lab reports
- to establish if ward 6 had a system for taking blood samples and managing lab reports (partly covered in the Trust Policy on Case Note Standards)

(12) **Was there any discussion of Raychel's case in nurse meetings, nursing reviews, nursing audits or learning sessions? If so, please provide any record thereof and describe:**

(a) **The learning derived therefrom;**

I can recall meeting with ward 6 staff to discuss the fluid balance chart and the standard of record keeping. A subsequent trust wide audit of fluid balance charts was undertaken

(b) **Those steps taken to utilise the learning.**

The findings of the audit were shared with nursing but I cannot recall nor do I have access to any minutes of this meeting.

(13) With respect to the Critical Incident Review meeting held on 12th June 2001 please confirm:

(a) **How much time was devoted to the meeting on 12th June 2001, giving approximate times of commencement and conclusion;**

From my memory it was an afternoon meeting and lasted about two hours

(b) **Was the Clinical Incident Form completed;**

At that point I did not know if this was completed

(c) **Was the Nursing Director, the Clinical Effectiveness Co-ordinator or the Clinical Services Manager (CSM) present at the Review meeting;**

I was present. The director of Nursing was not and I cannot recall if the CSM was present

(d) **Was the Clinical Audit Co-ordinator involved in the review process;** Not that I recall

(e) **Was any attempt made to locate and secure all documentation relating to Raychel Ferguson and her treatment;**

I was not involved in this aspect of the investigation.

(f) **Who was responsible for compiling a list of the relevant clinicians involved for the purposes of Review, and how was this done;**

I think this would have been the role of the Clinical Director and Risk Manager

(g) **Who was invited to attend the Review and whether any record exists to identify those who attended the Review;**

I do not know who was invited to attend the review but. I am aware, having reviewed Dr Fulton's statement who was present.

(h) **Was any attempt made to trace the Paediatric and Surgical rotas for 7th 9th June inclusive;**

I have no recall if this was done

(i) **Was any attempt made to form a chronology of the care and treatment provided to Raychel Ferguson;**

From my recall of the meeting the sequencing of the events for Raychel was discussed and time was spent discussing the facts of the matter

(j) **Which members of staff were interviewed, when and by whom, and whether this process**

was recorded or noted; I was not involved in interviewing staff

(k) Whether any statements were taken as part of the Review;

I am aware that staff had given statements in accordance with the process to investigate a clinical incident. I was not involved in this activity

(l) Whether and when an appreciation first arose that the case had the potential for litigation;

I have no recall of this

(m) What timescale was agreed for the provision of a written report to the Chief Executive, who wrote the report, when, to whom was it submitted and why has a copy of the same not been made available to the Inquiry;

I was not involved in agreeing or writing any report so cannot answer any parts of this question.

(n) Was any note/minute/memorandum/record taken of any part of the Review meeting;

A list of actions were recorded following the review meeting

(o) What further investigations were carried out by the Review team after the meeting;

I understand that a number of discussions were held between the CMO and the medical directors.

Regional IV guidance was developed and charts for fluid management were developed

(p) Were there any additional or subsequent meetings of the Review team? If so when and who attended;

I recall being at a further meeting in April 2002

I also spoke with the Chief Executive to report on actions I had taken

(q) What shortcomings and deficiencies were identified by the Review;

A need for the Trust to provide support and development for staff around fluid balance charts and record keeping.

At that time the method of recording the vomit would have been the use of descriptors such as small medium or large and or the use of the + sign.

It was agreed that staff would avoid the use of the plus sign and try to provide a description of the size and type of vomit at all times to ensure consistency of understanding.

Recording of urine output was to be reviewed - if the child could use the toilet parents should be advised and given a disposal pan to place over the toilet to try ensure accuracy. However, it was acknowledged both locally and at regional level that monitoring urinary output in young children can be challenging for a number of reasons.

Was the Review aware of the *"rumour"* from the RBHSC that there had been mis-

management of Raychel's fluids;

I am aware of this rumour but cannot recall how or when I became aware of it

(r) When and how did the Review team first become aware that the RBHSC had discontinued the use of Solution 18;

I cannot recall

(s) Whether or not you received a report in writing into the case of Raychel Ferguson? If so please provide the same;

No, I have no recall of receiving such a report

(t) what steps were expected to be taken by you to ensure that the recommendations arising from this Review were implemented?

I was required to take forward the actions identified at question 11

(14) Please provide the following information:

(a) When did you first become aware of the death of Raychel Ferguson?

From my recall I became aware on the 11th June 2001

(b) What action did you take in response thereto?

This has been detailed in question 11

(c) Was there any appraisal/review of staff performance in the aftermath of Raychel's death?
I was not responsible for undertaking reviews or appraisals for staff

(d) Whether you would have expected nursing staff to pursue an investigation into the death of Raychel Ferguson and whether you would have expected statements to have been obtained from the nurses in respect of same?

As Raychel's death was being investigated under the Trust Clinical Incident reporting process this would have included obtaining statements for all staff involved.

(e) How lessons learned were to be communicated across the AHHSST?

Solution 18 was removed from wards

Education sessions were provided on fluid management

Guidance charts on IV fluid prescribing were provided at ward level

(f) Was any consideration given to inviting external specialists to review the case of Raychel Ferguson?

I am aware that there have been independent investigations into the incident

(g) Was there any attempt to review ward practices and conventions to determine whether

they were appropriate, and whether they might better be reduced to writing as clinical protocols?

I have no knowledge of this

(h) Did you play any role in the revision or production of clinical protocols?

No - This would have been the role and responsibility of the Clinical Service Manager and Clinical lead

(i) Were you aware that there had been a ward practice in place in 2001 which favoured the use of Solution 18? If so please describe your understanding of this practice, from whom or where it originated, and who was responsible for implementing and monitoring it?

At the time of Raychel's death I was unaware of a ward policy that favoured the use of Solution 18

(j) When were you informed of the outcome of the Critical Incident Review, by whom and in what terms; and what steps were expected to be taken by you to ensure that the recommendations arising from this Review were implemented?

I cannot recall who or where I was informed of the outcomes of the review team but was aware from the on-going work for example the withdrawal of Solution 18; the development of the education sessions and the introduction of the wall chart outlining prescribing of IV fluids of the issues we wished to address following the review.

What information did you seek in relation to the case of Raychel Ferguson, what meetings did you have and what personal fact finding did you undertake/instigate?

I reviewed the fluid balance records with the staff in ward 6 discussing the best practice approach to fluid balance and record keeping in relation to this. Subsequently I organised additional training days to compliment the mandatory study days which include a session on fluid management by Dr Nesbitt.

(k) Why was the problem of Post Operative Nausea and Vomiting not incorporated in the Episodic Care Plan?

I cannot say why this aspect of care was not included

(l) Details of any changes in nursing care practice following the death of Raychel Ferguson?

Key changes included:

- Removal of solution 18 from use in the wards
- The provision of the IV fluid prescribing wall carts
- Changes in fluid prescribing fluid
- Changes to the way fluid balance charts were to be completed
- System introduced to manage urea and electrolytes including the frequency of these tests

(m) Please describe the extent to which you believe the Ferguson family was fully informed

of the causative factors of Raychel's death?

I was not involved in meeting with the Ferguson family so cannot say

(n) Was any consideration given to performing a detailed audit of all aspects of the case?

A critical incident investigation would include a thorough investigation of all aspects of the case including medical, nursing and any other relevant health care professionals records of care and treatment

(o) Whether there were shortcomings in the nursing care provided to Raychel Ferguson?

Please see answer to question 13 Q

(p) Whether the bleeper system was efficient?

I am not aware of any problems

(q) Whether responsibility was properly balanced between medical and nursing staff in respect of monitoring patients?

Nursing and medical staff work on a partnership basis.

Nurses are the constant for the patient and medical staff depend on nurses skills and observations to help inform the medical care and treatment of an individual patient.

Nursing staff are responsible for assessing nursing care requirements, for the provision of safe and effective standards of nursing care and for on- going monitoring of patients in response to treatments prescribed by medical colleagues.

Nurses are required to raise any concerns they may have about the condition of a patient in their care outlining what these changes in their condition are with the medical staff.

When a nurse has raised concerns about their patient it is the responsibility of the medical staff to see and examine the patient and to make the decisions about changes to their care and treatment including the ordering of tests.

Both sets of skills and expertise are required to provide rounded care of a patient but the roles and responsibilities are different.

(r) **Whether the fluid balance documentation was adequate?**

The recording of the fluid balance sheet for Raychel was inadequate and fell below the required standard

(s) Whether the computerised presentation of blood results was appropriate and adequate?

We had hoped to have all abnormal lab reports flagged but Dr O'Kane advised this was technically not possible at that time

(15) **In the aftermath of the death of Raychel Ferguson did you have reason to consider if there had been any systemic failings within the services for which you were responsible (and if so please include details)?**
I was not responsible for services

(16) Was there any reference to Raychel's case at any hospital committee meetings or in any other healthcare context? If so, please provide any record thereof.

I did not normally attend these meetings so cannot sate

(17) With reference to the Update for Chief Executive Re: Critical Incident Meeting (Ref: 022-097-308) please state the following:

(a) Was the meeting referred to at paragraph 4 minuted? If so please provide;

I do not know

(b) Who convened this meeting and was there an agenda;

I cannot recall this detail

(c) In respect of the note *"further action required. Mrs. Witherow to keep documentation under review"* please state why you were required to maintain documentation under review, what you did in this respect and to with what outcome;

I had just completed a review of the documentation in 1999/2000 and presented findings to the Hospital Management Team.

I organised a re- audit of nursing records and the instigation of a fluid balance audit in 2002 to ascertain if any improvements had been made .

We were aware that a regional fluid balance chart was being designed – Sister Mckenna was representing the Trust on this regional group and it was agreed that we would wait until this was available and change to this chart.

From my recall the new regional fluid balance chart was introduced in 2002

Did you share the concern of the nursing staff that surgeons were unable to give a commitment to children on Ward 6 and is so please describe when this became a concern and what steps you took to address it;

I was aware that this concern was held but cannot recall the exact period of time.

I was also aware that discussions were being held to rectify these

How the agreement in respect of fluid balance management was implemented, monitored and enforced?

This was shared with the staff in ward 6. The ward sister was responsible for ensuring the changes were made and sustained. Subsequent audit was designed to check if the improvement happened.

(18) In respect of the Critical Incident Review Meeting of 9th April 2002 (Ref: 022-092-299) please state:

(a) Who was present at this meeting;

Dr Fulton Theresa Brown Sister Millar and myself

(b) **Was there an agenda;**

I cannot recall

(c) **Was it minuted;**

I cannot recall and these cannot be located

(d) **To whom did it report;**

I think it was to Mrs Burnside the Chief Executive

What was the purpose, in April 2002, of reviewing *"the action plan of the Critical Incident Meeting of 12-6-2001"*;

My understanding of the purpose of this meeting was to review the actions that had been agreed in June 2001 and to ascertain if they had been completed and or if any were unresolved and outstanding.

(e) **In relation to paragraph 2, and the arrangement for daily U&E tests-** *"this was immediately actioned by Sister Millar. The Phlebotomists take the blood. It is not clear who is responsible for ordering the blood. Mrs. Witherow and Mrs. Brown will prepare Ward guidelines. Acion [sic] T. Brown, A.Witherow."* **Please state:**

(i) **Whether ward guidelines were prepared and if so please identify the same;**

When this was reviewed Sister Millar confirmed there was a working process now in place at ward level which identified the roles and responsibilities s of the staff in relation to bloods samples. .

(ii) **Whether these guidelines were successfully implemented;**

My recall this is the case and this was confirmed at the meeting in April 2002 by Sister Millar

(g) **What mechanisms were used to implement, monitor and enforce such Ward guidelines?**

I was not responsible for such monitoring so cannot answer this

(h) **In relation to** *"at the moment blood results come up on the computer. This does not show the normal range... Anne Witherow to speak to Dr. M. O'Kane to ascertain if the normal ranges can be put on the computer. Action A. Witherow"* **please state:**

(i) **Did you fulfil this task;**

Yes - I spoke with Dr O'kane and discussed this request with him

(ii) **Was the computer presentation of blood results amended appropriately, and if so when?**

No, I was advised this was not possible at that time due to some technical issues.

(18) **Please provide such further comment as you think relevant. It would be of very considerable assistance if you could attach any documents you may hold which may be relevant to procedures, strategies, policies or any such issues as you think may be relevant.**

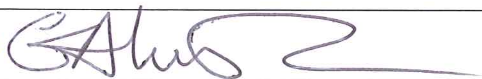
During all of my 38 years as a nurse the most painful experience I have had is to nurse a child who subsequently died and to recognize the dark journey this brings for parents, family and friends.

The distress for me as a nurse cannot be compared to that of the parents, brothers and sisters and grandparents of a child who dies and is a life defining event of enormous magnitude.

I was not personally involved with Mr and Mrs Ferguson nor did I nurse little Raychel when she was on ward 6 in Altnagelvin.

I would like to offer my sincere sympathy and genuine sadness at the significant impact the loss of Raychel has brought for Mr and Mrs Ferguson and the wider family circle and it is my personal hope and prayer that this Inquiry will provide what the family need at this point in time and that my statement will contribute to that end.

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

Signed:  **Dated:** 2/7/2013

CV

Name: Georgina Anne Witherow
DOB:
Address:
Email
Phone

Nationality:

Education:
Portstewart Primary School 1960-1967
Coleraine Girl's Secondary School 1967-1973
Coleraine Technical College 1972 -1974
Royal Victoria Hospital for RGN training 1974-1977
Great Ormond Street for RSCN training 1979-1980
Diploma in Health Studies at University Ulster Coleraine 1992-1995
Post graduate diploma in wound healing and repair at Cardiff University 1995-1998
Clinical Micro Systems Management – Dartmouth College America October 2009

Currently I am undertaking he Institute of Health Improvement Open School Programme - Governance and Risk Management

Current Post

Assistant Director of Nursing, Western Health and Social Care Trust.
Appointed June 2007

Key Responsibilities

Main responsibilities through the Executive Director of Nursing include

- The development and delivery of a range of high quality, safe and effective governance services.
- Lead on the strategic planning of the Trust's nursing and midwifery governance performance and quality services and ensure effective multidisciplinary
- Responsible for providing strong professional leadership and for ensuring high standards of patient/client experience in all health and social care services.
- Specifically lead strategic development of Nursing and Midwifery standards & performance management systems, including clinical governance, policies & procedures, standards & guidelines and development and monitoring of Key performance Indicators

- Provide clear leadership and oversee the management redesign and modernisation of all staff involved in Tissue Viability service and Resuscitation Services
- Provide expert advice and leadership in relation to nursing and midwifery governance, patient safety and user experience
- Lead on Environmental Cleanliness ensuring the Regulation Quality and Improvement Authority inspections are auctioned appropriately
- Establish effective accountability meetings to monitor performance with key performance indicators
- Lead on the implementation of the Releasing Time to Care Series
- Lead on the Evidencing Care through Record Keeping Project
- Controls assurance as appropriate
- Manage and chair in the absence of the Executive Director Nursing the Trust Nursing Midwifery Governance meeting

Regional Groups
Represent the Trust on the following groups

- Regional Patient and Client Experience group
- Regional Nutritional Group
- Regional Key Performance Indicators
- Regional Falls Prevention group
- Public Health Authority Governance group
- Regional Nursing assistant Directors Forum
- Evincing Care through Record Keeping – chair working group

Recent Awards

AUDIT 2009 Received from the Department of Health - GAIN Audit Committee £20,000
To support a review and improvement in the use of Early Warning Scores

2009-2010 Received from GAIN £6.000 to conduct a review of staff knowledge on Falls Prevention

209-2011 Research Grant awarded internally £5,000 for pilot study into Patients Experience of Direct Payments

2012 Florence Nightingale Travel Scholarship Award - Promoting Privacy and Dignity. Anticipated dates of travel - Sept 2012 to Boston

Previous Post
Period 1997-2007

Post - Clinical Effectiveness Co-ordinator / Tissue Viability Nurse Specialist, Altnagelvin Hospital, Londonderry

Clinical Effectiveness Responsibilities

- Support nursing staff deliver on the Clinical Effectiveness agenda within the Clinical Governance framework of Altnagelvin Health and Social Services Trust
- Line Management responsibilities for Clinical Audit and Practice development

Tissue Viability Nurse Responsibilities

- Leading and managing the tissue viability service for the Trust, includes Nurse led clinics in diabetic foot management with podiatry, leg ulcer care and general surgical wounds.
- Provide specialist advice to all teams across the trust and take direct patients referrals and carry a case load off my own that is generated form the different consultants, departments and from the A&E department within the Trust.
- Line management responsibility for Tissue Viability staff

1992-1997 Clinical Nurse Specialist in Altnagelvin Hospital

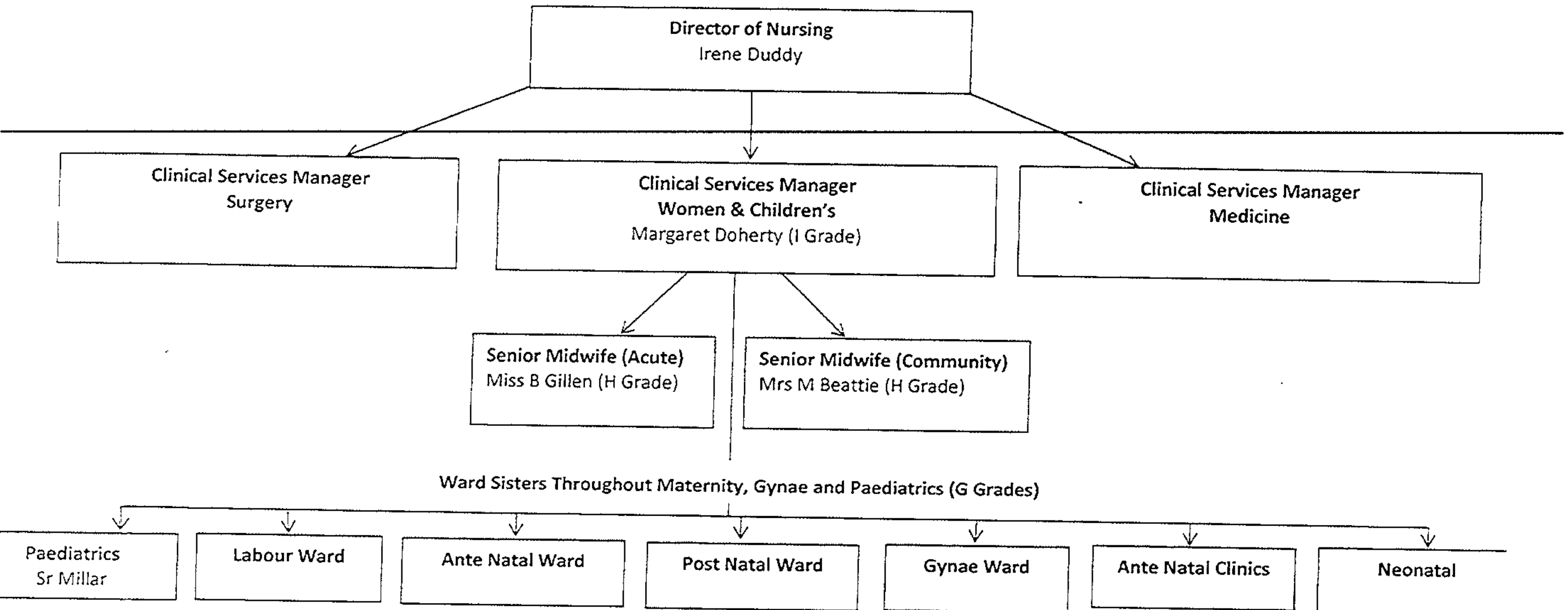
This post was a generic specialist nurse post combining management and clinical work. It was during this time that I undertook a major audit and improvement programme in relation to the prevention of pressure ulcers which formed the next steps to apply for the Tissue Viability and Clinical Effectiveness Co-ordinators post.

1980-1992
After qualifying as a registered general nurse and registered sick children's nurse I held a variety of staff nurse in the acute medical and critically care environments taking a short career break during 1982-1984 to have two children. I worked for a period of 5 years as manager of a private nursing home

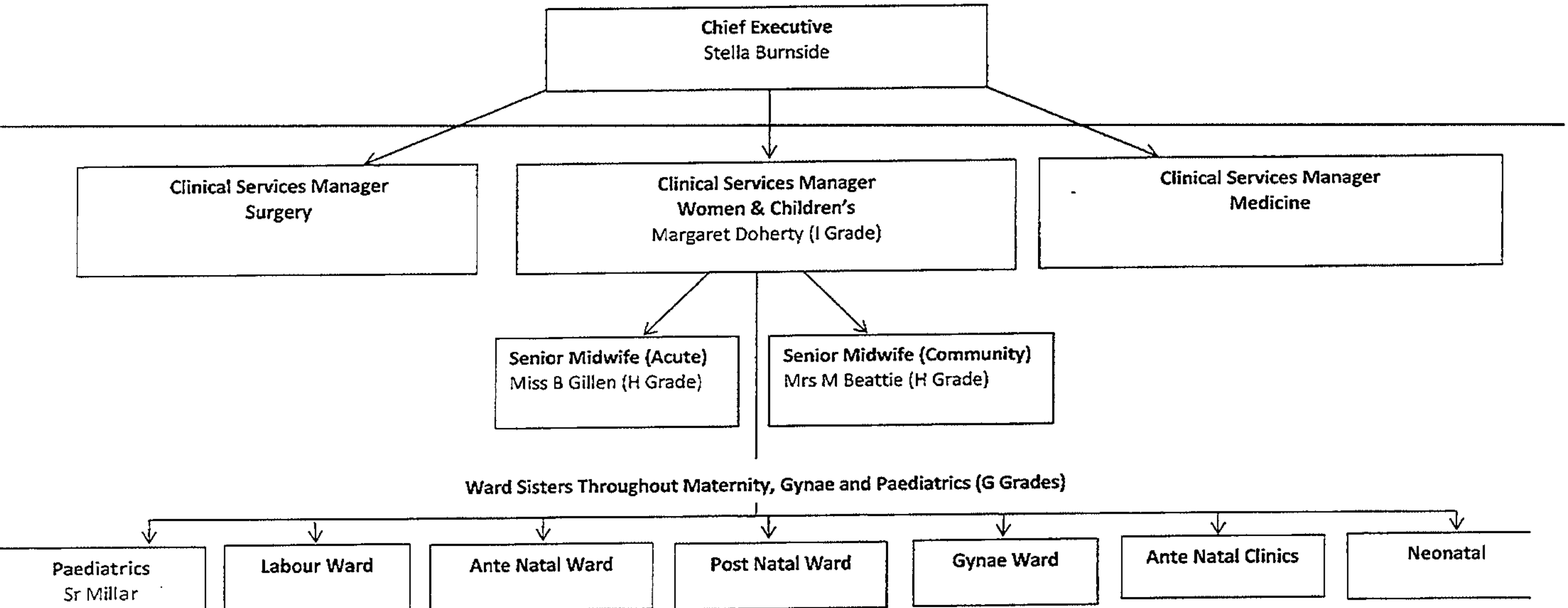
1979-1980
Post Graduate RSCN training programme Great Ormonde Street London

1977-1979
I worked a staff nurse in the Royal Victoria Hospital Belfast in cardiology and general medical wards

1974-1977
Student Nurse Training Royal Victoria Hospital Belfast



Professional Accountability Flow Chart
Director of Nursing
Irene Duddy
Clinical Services Manager
Surgery
Clinical Services Manager
Women & Children's
Margaret Doherty (I Grade)
Clinical Services Manager
Medicine
Senior Midwife (Acute)
Miss B Gillen (H Grade)
Senior Midwife (Community)
Mrs M Beattie (H Grade)
Ward Sisters Throughout Maternity, Gynae and Paediatrics (G Grades)
Paediatrics
Sr Millar
Labour Ward
Ante Natal Ward
Post Natal Ward
Gynae Ward
Ante Natal Clinics
Neonatal



Line Management Flow Chart
Chief Executive
Stella Burnside
Clinical Services Manager
Surgery
Clinical Services Manager
Women & Children's
Margaret Doherty (I Grade)
Clinical Services Manager
Medicine
Senior Midwife (Acute)
Miss B Gillen (H Grade)
Senior Midwife (Community)
Mrs M Beattie (H Grade)
Ward Sisters Throughout Maternity, Gynae and Paediatrics (G Grades)
Paediatrics
Sr Millar
Labour Ward
Ante Natal Ward
Post Natal Ward
Gynae Ward
Ante Natal Clinics
Neonatal

Guidelines for professional practice

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United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Protecting the public through professional standards

Guidelines for professional practice

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United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

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Preamble

The UKCC has produced this booklet to provide a guide for reflection on the statements within the Code of Professional Conduct. For students and those of you who are new to the professions, we hope that you find it useful; others of you may be very familiar with the guidance provided. This booklet has been produced to help to reflect on the many challenges that face us in day-to-day practice. The booklet should be read as a whole and care should be taken to use each section in the context of all the guidance provided. It is important that time is taken to read and consider the whole document. You may find yourself in a crisis when there is no opportunity to reach for a book. At these times, you may need the guidance offered to make the professional judgement needed for that specific situation.

Once you have read the booklet, you will be able to dip into the relevant sections and we hope that you will use it regularly and reflect on the many subjects covered. Throughout this booklet, many general ethical and legal issues have been covered. However, it is important that you get to know the specific circumstances, safeguards, policies and procedures needed to provide treatment or care relevant to your area of practice.

The development of these guidelines has been a consultative process with input from individuals with different employment, education, consumer and practice backgrounds. It has been produced in order to replace and update the information provided in the following three documents; Exercising Accountability (March 1989), Confidentiality (April 1987) and Advertising by Registered Nurses, Midwives and Health Visitors (March 1985).

With the many challenges facing nurses, midwives and health visitors and the speed in which practice changes, we acknowledge that these guidelines for professional practice will require regular review. We will formally review the contents by June 1998 and, in the meantime, would welcome any comments you have. These should be sent to the Professional Officer, Ethics, at the UKCC's address.

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Introduction

1 The UKCC's responsibilities are set out in the Nurses, Midwives and Health Visitors Acts for 1979 and 1992 and our main responsibility is to protect the interests of the public. To do this, we set standards for education, training and professional conduct for registered nurses, midwives and health visitors (registered practitioners). The motto on our coat of arms – 'care, protect, honour' – reflects these responsibilities. We hope that this booklet will help you to:

- 'care' in a way that reflects your code of professional conduct (the UKCC Code of Professional Conduct 1992);
- 'protect' patients and clients and
- 'honour' your responsibilities as a registered practitioner.

2 With so many codes and charters about, it is easy to be confused about how they relate to your professional and personal life. The Code of Professional Conduct was drawn up by the UKCC under the powers of the Nurses, Midwives and Health Visitors Act 1979 to give advice to registered practitioners. This code sets out:

- the value of registered practitioners;
- your responsibilities to represent and protect the interests of patients and clients and
- what is expected of you.

3 The role of the UKCC in protecting the public is firstly to maintain a register of people who are recommended to be suitable practitioners and who have demonstrated knowledge and skill through a qualification registered with the UKCC. Secondly, we can remove people from that register either because they are seriously ill or because a charge of misconduct has been proven against them. The code is used as the standard against which complaints are considered.

4 This booklet gives guidance on all sixteen clauses of the code. It deals with areas such as consent, truthfulness, advocacy and autonomy. It cannot deal with every conflict which a registered practitioner may face. We recognise

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that professional practice and decision-making are not straightforward. The circumstances we work under are always changing. The way we work must be sensitive and relevant and must meet the needs of patients and clients. We must be able to adjust our practice to changing circumstances, taking into consideration local procedures, policies and cultural differences.

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Accountability – answering for your actions

5 As a registered practitioner, you hold a position of responsibility and other people rely on you. You are professionally accountable to the UKCC, as well as having a contractual accountability to your employer and accountability to the law for your actions. The Code of Professional Conduct sets out your professional accountability – to whom you must answer and how. The code begins with the statement that:

> "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."

Each clause of the code begins with the statement 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 ..."

No one else can answer for you and it is no defence to say that you were acting on someone else's orders.

6 In exercising your professional accountability, there may be conflict between the interests of a patient or client, the health or social care team and society. This is especially so if health care resources are limited. Whatever decisions you take and judgements you make, you must be able to justify your actions.

7 Accountability is an integral part of professional practice, as in the course of practice you have to make judgements in a wide variety of circumstances. Professional accountability is fundamentally concerned with weighing up the interests of patients and clients in complex situations, using professional knowledge, judgement and skills to make a decision and enabling you to account for the decision made. Neither the Code of Professional Conduct nor this booklet seek to state the circumstances in which accountability has to be exercised, but instead they provide principles to aid your decision making.

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Working together

42 The UKCC recognises the complexity of health care and stresses the need to appreciate the contribution of professional health care staff, students, supporting staff and also voluntary and independent agencies. Providing care is a multi-professional, multi-agency activity which, in order to be effective, must be based on mutual understanding, trust, respect and co-operation. Patients and clients are equal partners in their care and therefore have the right to be involved in the health care team's decisions.

43 Under clause 6 and clause 14 of the Code of Professional Conduct:

> "As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, must ...
>
> 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; ...
>
> 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 to a degree appropriate to their roles;"

These clauses emphasise the importance of support and co-operation and also the importance of avoiding disputes and promoting good relationships and a spirit of co-operation and mutual respect within the health and social care team. It is clearly impossible for any one profession to possess all the knowledge, skills and resources needed to meet the total health care needs of society. Good care should be the product of a good team.

44 Good team work is important but co-operation and collaboration are not always easily achieved, for example, if:

- individual members of the team have their own specific and separate objectives or

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- one member of the team tries to adopt a dominant role without considering the opinions, knowledge and skills of its other members.

In such circumstances, achieving good team work needs hard work and negotiation between all the health care professionals involved. In all the discussions, it is important to stress that the interests of the patient or client must come first.

45 Discrimination has no place in health care. This means making sure that equal opportunities policies are in place, challenged and/or changed and ensuring that no one has to endure racial or sexual harassment. Each member of a team is entitled to equality and must not be discriminated against because of gender, age, race, disability, sexuality, culture or religious beliefs. There needs to be effective communication and team work to make sure these principles are not neglected.

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Conscientious objection

46 In today's developing health service, you may find yourself in situations which you find very uncomfortable. There may be many circumstances in which a practitioner, due to personal morality or religious beliefs, will not wish to be involved in a certain type of treatment or care. Clause 8 of the Code of Professional Conduct states 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 ...
>
> 8 report to an appropriate person or authority, at the earliest possible time, any conscientious objection which may be relevant to your professional practice;"

47 In law, you have the right conscientiously to object to take part in care in only two areas. These are the Abortion Act 1967 (Scotland, England and Wales), which gives you the right to refuse to take part in an abortion, and the Human Fertilisation and Embryology Act 1990, which gives you the

right to refuse to participate in technological procedures to achieve conception and pregnancy.

48 However, in an emergency, you would be expected to provide care. You should carefully consider whether or not to accept employment in an area which carries out treatment or procedures to which you object. If, however, a situation arises in which you do not want to take part in a form of treatment or care, then it is important that you declare your objection in time for managers to make alternative arrangements. In certain circumstances, this may mean providing counselling for the staff involved in these decisions. You do not have the right to refuse to take part in emergency treatment.

49 Refusing to be involved in the care of patients because of their condition or behaviour is unacceptable. The UKCC expects all registered practitioners to be non-judgmental when providing care. This is one of the issues addressed by clause 7 of the code, which states 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 ...
>
> 7 recognise and respect the uniqueness and dignity of each patient and client, and respect their need for care, irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problems or any other factor;"

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Confidentiality

50 To trust another person with private and personal information about yourself is a significant matter. If the person to whom that information is given is a nurse, midwife or health visitor, the patient or client has a right to believe that this information, given in confidence, will only be used for the purposes for which it was given and will not be released to others without their permission. The death of a patient or client does not give you the right to break confidentiality.

51 Clause 10 of the Code of Professional Conduct addresses this subject directly. It states 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 ...
>
> 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;"

Confidentiality should only be broken in exceptional circumstances and should only occur after careful consideration that you can justify your action.

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52 It is impractical to obtain the consent of the patient or client every time you need to share information with other health professionals or other staff involved in the health care of that patient or client. What is important is that the patient or client understands that some information may be made available to others involved in the delivery of their care. However, the patient or client must know who the information will be shared with.

53 Patients and clients have a right to know the standards of confidentiality maintained by those providing their care and these standards should be made known by the health professional at the first point of contact. These

standards of confidentiality can be reinforced by leaflets and posters where the health care is being delivered.

Providing information

54 You always need to obtain the explicit consent of a patient or client before you disclose specific information and you must make sure that the patient or client can make an informed response as to whether that information can be disclosed.

55 Disclosure of information occurs:

- with the consent of the patient or client;
- without the consent of the patient or client when the disclosure is required by law or by order of a court and
- without the consent of the patient or client when the disclosure is considered to be necessary in the public interest.

56 The public interest means the interests of an individual, or groups of individuals or of society as a whole, and would for example, cover matters such as serious crime, child abuse, drug trafficking or other activities which place others at serious risk.

57 There is no statutory right to confidentiality but an aggrieved individual can sue through a civil court alleging that confidentiality was broken.

58 The situation that causes most problems is when your decision to withhold confidential information or give it to a third party has serious consequences. The information may have been given to you in the strictest confidence by a patient or client or by a colleague. You could also discover the information in the course of your work.

59 You may sometimes be under pressure to release information but you must realise that you will be held accountable for this. In all cases where you deliberately release information in what you believe to be the best interests of the public, your decision must be justified. In some circumstances, such as accident and emergency admissions where the police are involved, it may be appropriate to involve senior staff if you do not feel that you are able to deal with the situation alone.

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60 The above circumstances can be particularly stressful, especially if vulnerable groups are concerned, as releasing information may mean that a third party becomes involved, as in the case of children or those with learning difficulties.

61 You should always discuss the matter fully with other professional colleagues and, if appropriate, consult the UKCC or a membership organisation before making a decision to release information without a patient's permission. There will often be significant consequences which you must consider carefully before you make the decision to withhold or release information. Having made a decision, you should write down the reasons either in the appropriate record or in a special note that can be kept in a separate file (outlined in the UKCC's booklet Standards for Records and Record Keeping). You then have written justification for the action which you took if this becomes necessary and you can also review the decision later in the light of future developments.

Ownership of and access to records

62 Organisations which employ professional staff who make records are the legal owners of these records, but that does not give anyone in that organisation the legal right of access to the information in those records. However, the patient or client can ask to see their records, whether they are written down or on computer. This is as a result of the Data Protection Act 1984, Access Modification (Health) Order 1987 and the Access to Health Records Act 1990.

63 The contracts of employment of all employees not directly involved with patients but who have access to or handle confidential records should contain clauses which emphasise the principles of confidentiality and state the disciplinary action which could result if these principles are not met.

64 As far as computer-held records are concerned, you must be satisfied that as far as possible, the methods you use for recording information are secure. You must also find out which categories of staff have access to records to which they are expected to contribute important personal and confidential

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information. Local procedures must include ways of checking whether a record is authentic when there is no written signature. All records must clearly indicate the identity of the person who made that record. As more patient and client records are moved and linked between health care settings by computer, you will have to be vigilant in order to make sure that patient or client confidentiality is not broken. This means trying to ensure that the systems used are protected from inappropriate access within your direct area of practice, for example ensuring that personal access codes are kept secure.

65 The Computer Misuse Act 1990 came into force to secure computer programs and data against unauthorised access or alteration. Authorised users have permission to use certain programs and data. If those users go beyond what is permitted, this is a criminal offence. The Act makes provision for accidentally exceeding your permission and covers fraud, extortion and blackmail.

66 Where access to information contained on a computer filing system is available to members of staff who are not registered practitioners, or health professionals governed by similar ethical principles, an important clause concerning confidentiality should appear within their contracts of employment (outlined in the UKCC's position statement Confidentiality: use of computers, 1994).

67 Those who receive confidential information from a patient or client should advise them that the information will be given to the registered practitioner involved in their care. If necessary, this may also include other professionals in the health and social work fields. Registered practitioners must make sure that, where possible, the storage and movement of records within the health care setting does not put the confidentiality of patient information at risk.

Access to records for teaching, research and audit

68 If patients' or clients' records need to be used to help students gain the knowledge and skills which they require, the same principles of confidentiality apply to the information. This also applies to those engaged

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in research and audit. The manager of the health care setting is responsible for the security of the information contained in these records and for making sure that access to the information is closely supervised. The person providing the training will be responsible for making sure that students understand the need for confidentiality and the need to follow local procedures for handling and storing records. The patient or client should know about the individual having access to their records and should be able to refuse that access if they wish.

69 In summary, the following principles concerning confidentiality apply:

- a patient or client has the right to expect that information given in confidence will be used only for the purpose for which it was given and will not be released to others without their permission;
- you should recognise each patient's or client's right to have information about themselves kept secure and private;
- if it is appropriate to share information gained in the course of your work with other health or social work practitioners, you must make sure that as far as is reasonable, the information will be kept in strict professional confidence and be used only for the purpose for which the information was given;
- you are responsible for any decision which you make to release confidential information because you think that this is in the public's best interest;
- if you choose to break confidentiality because you believe that this is in the public's best interest, you must have considered the situation carefully enough to justify that decision and
- you should not deliberately break confidentiality other than in exceptional circumstances.

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Advertising and sponsorship

70 Clause 16 of the UKCC's Code of Professional Conduct addresses the subject of the promotion of commercial goods or services. It states 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 ...
>
> 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."

71 Patients or clients and their relatives or friends are often anxious when attending hospitals and other health care facilities. The environment of care should help to promote good health, healing and recovery and not be one of commercial advertising.

72 Clause 16 does not intend to prevent registered practitioners employed in positions such as the matron of a private nursing home or as a representative of a pharmaceutical company, or who are offering their professional services privately, from using their registration status on items such as business cards and headed note paper.

73 However, if a practitioner has a direct financial or other direct interest in an organisation providing commercial goods or services, for example, a ward sister who is discharging a patient to a nursing home owned and run by herself or one of her relatives, then that practitioner must make her interests known.

74 It is also unacceptable for registered practitioners to carry commercial advertising or promotional material on their uniforms.

75 Under the Code of Professional Conduct, registered practitioners must protect the interests of patients and clients, be worthy of public trust and confidence and avoid using professional qualifications in ways which might

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compromise the independence of professional judgements upon which patients and clients rely. The vulnerability of patients and clients is reflected by these elements of the code, which also indicate the importance of trust between a registered practitioner and a patient as well as the expectation that the registered practitioner will respond to the patient's needs unconditionally.

Sponsorship

76 Funding for some posts, projects or services is sometimes offered by companies, some of which have a commercial interest in matters associated with health care. Sponsorship arrangements which affect the professional judgement of registered practitioners and patient or client choice should be brought to the attention of those who provide health care services.

77 Students on pre-registration and post-registration courses often need sponsorship to carry out their study, especially for overseas study visits. The decision to accept sponsorship must be made by the individual, taking account of the appropriateness of the support offered.

Receiving gifts

78 You may be offered gifts, favours or hospitality from patients or clients during the course of or after a period of care or treatment. The Code of Professional Conduct states that:

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

The important principle is not that the registered practitioner never receives gifts or favours but that they could never be interpreted as being given by the patient or client in return for preferential treatment.

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Complementary and alternative therapies

79 Complementary therapies are gaining popularity and finding a more substantial place in health care. It is vitally important that you ensure that the introduction of any of these therapies to your practice is always in the best interests and safety of the patients and clients. Clause 9 of the code outlines your privileged relationship with patients and clients:

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

The registered practitioner therefore must be convinced of the relevance and accountability of the therapy being used and must be able to justify using it in a particular circumstance, especially when using the therapy as part of professional practice. It should also be part of professional team work to discuss the use of complementary therapies with medical and other members of the health care team caring for the particular patient or client.

80 Some registered practitioners, who successfully complete courses in complementary or alternative therapies not usually associated with their professional practice, quote their registration status when advertising their services. The UKCC believes that a person's registration status should not be needed to support a complementary or alternative therapy course or qualification if the course is valid and credible. However, if it is a registered practitioner's registered status that gives credibility to the qualification, then the registered practitioner must use their own judgement and discretion to make sure that they are not misleading the public.

81 If a complaint is made against you, we can call you to account for any activities carried out outside conventional practice. You should carefully consider the content and status of any courses which you undertake and how you promote yourself.

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Research and audit

82 Increasing numbers of registered practitioners are carrying out, or are involved in, research or audit. The results might improve practice, help to audit an aspect of clinical services, inform policy or be part of a graduate or postgraduate qualification. Other practitioners are employed or involved with clinical trials which focus on new treatments, new technology or improvements to patient care.

83 If you are involved in these activities, issues often arise which you need to consider. Is the research ethical? Is your role appropriate? Has the Local Research Ethics Committee (LREC) given its approval? Has local management given their approval? What is the make-up of the LREC? Are there registered practitioners on the LREC?

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Types of research

84 The range of research carried out varies greatly. Outlined below are some of the types of research that are used in the health care setting.

Projects

85 An increasing number of students are being asked to do project work for diplomas or undergraduate degrees. Many educational institutions recommend that their diploma or undergraduate students do not become involved in clinically-based research.

86 As the number of these projects increases, contact with patients or clients might be refused. This is quite reasonable, as the care and comfort of patients or clients must always be considered. Projects by registered practitioners may be prompted by developments at clinical level, by involvement in practice development units or as a result of participating in clinical supervision.

Higher degrees

87 Research for postgraduate degrees is supervised and guided throughout. It is important to gain approval for research in clinical areas from management in addition to consulting the local LREC before starting the work.

Other research work and clinical research trials

88 Research activities intended to benefit patient care or investigate practice are carried out by a wide range of clinicians, academics and others. Registered practitioners may be involved in this work as part of their job, because of academic interest or in response to a perceived or expressed need.

89 Contracts of employment specify how practitioners must work. They do not always cover concerns about the ethics of research, confidentiality, consent or other issues. Under European Community Directive 91/507/EEC, all elements of clinical trials carried out within the European Union must adhere to the guidelines on good clinical practice for trials on medical protocols in the EU. These guidelines provide a useful framework for nurses, midwives and health visitors to use when they are involved in research work.

90 If there is contact with patients or clients, it is important for you to discuss the benefits of the work with the appropriate manager. You must be certain that approval from the LREC is obtained. Repeated requests for patients and clients to fill in questionnaires or to be interviewed can be intrusive and potentially disruptive to care. For this reason, the views of patients, clients, and their associates will assist in determining prospective compliance.

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Criteria for safe and ethical conduct of research

91 You must always refer to the UKCC's Code of Professional Conduct and The Scope of Professional Practice. These documents provide the framework for all actions of registered nurses, midwives and health visitors.

92 As well as using these documents, you need to be sure that the research or clinical trial you are carrying out meets specific criteria. These are that:

- the project must be approved by the LREC;
- management approval must be gained where necessary;
- arrangements for obtaining consent must be clearly understood by all those involved;
- confidentiality must be maintained;
- patients must not be exposed to unacceptable risks;
- patients should be included in the development of proposed projects where appropriate;
- accurate records must be kept and
- research questions need to be well structured and aimed at producing clearly anticipated care or service outcomes and benefits;

93 You need to consider these criteria before submitting a research proposal to a LREC. You are expected to participate fully in the design process and this includes raising legitimate concerns when they arise. If no LREC exists in your area, it is important to refer to local policy for research.

Audit

94 Audit seeks to improve practice and treatment and to reduce risk by the systematic review of the process and outcome of care and treatment and by the evaluation of records and other data. There are occasions when contact with patients and clients, carers or relatives is necessary and therefore LREC clearance may be required. Consideration of the other points highlighted above is recommended.

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Conclusion

95 We have produced this booklet to help you in your professional practice. It would be impossible to discuss all the issues faced by registered practitioners. Answers are not always straightforward. The Code of Professional Conduct and The Scope of Professional Practice apply to all registered practitioners and the interests of the public, patients and clients are of the greatest importance. You should also remember that being accountable and working with those who provide care is the foundation upon which the best standards are achieved. With the many challenges facing nurses, midwives and health visitors and the speed in which practice changes, it is acknowledged that these guidelines for professional practice will require regular review. We will formally review these guidelines by June 1998 and, in the meantime, would welcome any comments which you may have. Comments on this booklet should be sent to the Professional Officer, Ethics, at the UKCC's address.

96 In producing this booklet, we have been greatly helped by comments from representatives of practice, education, medical, professional, membership and consumer organisations. We have tried to produce the booklet in a form that is easily accessible in order to aid professional judgement and to outline basic principles.

97 If you need further information or advice, please contact our team of professional officers at the:

Standards Promotion Directorate
United Kingdom Central Council
for Nursing, Midwifery and Health Visiting
23 Portland Place
London W1N 4JT

Telephone: 0171 637 7181
Fax: 0171 436 2924

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Documents relevant to these guidelines

1 *Code of Professional Conduct,* UKCC, 1992

2 *The Scope of Professional Practice,* UKCC, 1992

3 *Midwives Rules,* UKCC, 1993

4 *The Midwife's Code of Practice,* UKCC, 1994

5 *Standards for Records and Record Keeping,* UKCC, 1993

6 *Standards for the Administration of Medicines,* UKCC, 1992

7 *Confidentiality: use of computers, position statement,* UKCC, 1992

8 *Complementary therapies, position statement,* UKCC, 1995

9 *Acquired Immune Deficiency Syndrome and Human Immune Deficiency Virus Infection (AIDS and HIV Infection),* UKCC, 1994

10 *Anonymous Testing for the Prevalence of the Human Immune Deficiency Virus (HIV),* UKCC, 1994

These documents are available on written request from the Distribution Department at the UKCC.

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Laws relevant to these guidelines

1. Nurses, Midwives and Health Visitors Acts 1979 and 1992
2. Access to Health Records Act 1990
3. Family Law Reform Act 1969
4. Age of Legal Capacity (Scotland) Act 1991
5. Children Act 1989
6. Mental Health (Northern Ireland) Order 1986
7. Mental Health (England and Wales) Act 1983
8. Mental Health (Scotland) Act 1984
9. Abortion Act 1967
10. Human Fertilisation and Embryology Act 1990
11. Data Protection Act 1984
12. Access Modification (Health) Order 1987
13. Computer Misuse Act 1990
14. European Community Directive 91/507/EEC

These are available from your local branch of Her Majesty's Stationery Office (HMSO).

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Protecting the public through professional standards

8 If you delegate work to someone who is not registered with the UKCC, your accountability is to make sure that the person who does the work is able to do it and that appropriate levels of supervision or support are in place.

9 The first four clauses of the code make sure that you put the interests of patients, clients and the public before your own interests and those of your professional colleagues. They are as follows:

> "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;"

10 The code does not cover the specific circumstances in which you make decisions and judgements. It presents important themes and principles which you must apply to all areas of your work.

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Duty of care

11 You have both a legal and a professional duty to care for patients and clients. In law, the courts could find a registered practitioner negligent if a person suffers harm because he or she failed to care for them properly. Professionally, the UKCC's Professional Conduct Committee could find a registered practitioner guilty of misconduct and remove them from the register if he or she failed to care properly for a patient or client, even though they suffered no harm.

12 Lord Atkin defined the duty of care when he gave judgement in the case of Donoghue v Stephenson (House of Lords) (1932). He said that:

> "You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in the law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question."

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How circumstances can affect your duty of care

13 If there is a complaint against you, the UKCC's Professional Conduct Committee and possibly the courts would decide whether you took proper care. When they do this, they must consider whether what you did was reasonable in all the circumstances.

14 The following examples show how the duty of care changes according to the circumstances. Each example shows a skilled adult intensive care nurse in a different situation.

Example 1

The nurse is on duty in the intensive care unit when a patient suffers a cardiac arrest.

Here, it is reasonable to expect the nurse to care for the patient as competently as any experienced intensive care unit nurse.

Example 2
The nurse is walking along a hospital corridor and finds a woman completely alone giving birth.

In this situation, it is not reasonable to expect the nurse to care for the woman as a midwife would. But it is reasonable to expect the nurse to call a midwife or obstetrician and to stay with the woman until appropriate help arrives.

Example 3
The nurse is walking along a street and comes across a person injured in a road traffic accident.

In this situation, the nurse does not have a legal duty to stop and care for the injured person. But if she does, she then takes on a legal duty to care for the person properly. In these circumstances, it is reasonable to expect her to care for the person to the best of her skill and knowledge. Although the nurse has no legal duty to stop and give care in this example, she does have a professional duty. The Code of Professional Conduct places a professional duty upon her at all times. However, in this situation it could be reasonable to expect the nurse to do no more than comfort and support the injured person.

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What is reasonable?

15 The courts and the Professional Conduct Committee must decide whether your actions were reasonable. The care of Bolam v Friern Hospital Management Committee (1957) produced this test of what is reasonable:

> "The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent … it is sufficient if he exercises the skill of an ordinary competent man exercising that particular art."

16 This test is usually called the Bolam test. Although the case concerned a doctor, the Bolam test can be used to examine the actions of any professional person. The case of Wilsher v Essex AHA (1988) set the standard of

reasonable care to be expected of students and junior staff. The standard is that of a reasonably competent practitioner and not that of a student or junior. You have a duty to ensure that the care which you delegate is carried out at a reasonably competent standard. This means that you remain accountable for the delegation of the work and for ensuring that the person who does the work is able to do it. The Code of Professional Conduct provides principles which you can apply to any situation. If you use these principles, you will be able to carry out your legal and professional duty of care.

Withdrawing care to protect the public and yourself

17 There may be circumstances of conflict where the registered practitioner may consider withdrawing his or her care. A situation like this might occur if the registered practitioner fears physical violence or if there are health and safety hazards involved in providing care. There may be other situations where the registered practitioner may seek support or consider withdrawing care, for example due to sexual or racial harassment. Any decision to withdraw care has to be taken very carefully and you should first discuss, if possible, the matter with managers, the patient's or client's family and, if appropriate and wherever possible, the patient or client themselves. In certain circumstances, you may need help to make sure that the public are safe. If possible, you should discuss this with other members of the health care team. However, in areas of practice where violence may occur more frequently, such as in some areas of mental health care and in accident and emergency departments, there must be protocols to deal with these situations. Appropriate training and on-call support arrangements should also be available. In all cases, you should make a record of the fact that you withdrew care so that if your actions or decisions are questioned, you can justify them.

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Patient and client advocacy and autonomy

18 Recognising a patient's or client's right to choose is clearly outlined in clauses 1 and 5 of the code. Although the words advocacy and autonomy are not specifically used, it is this section which states the registered practitioner's role in these respects. The code states 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; (advocacy) ...
>
> 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;" (autonomy)

19 The registered practitioner must not practise in a way which assumes that only they know what is best for the patient or client, as this can only create a dependence and interfere with the patient's or client's right to choose. Advocacy is concerned with promoting and protecting the interests of patients or clients, many of whom may be vulnerable and incapable of protecting their own interests and who may be without the support of family or friends. You can do this by providing information and making the patient or client feel confident that he or she can make their own decisions. Advocacy also involves providing support if the patient refuses treatment/care or withdraws their consent. Other health care professionals, families, legal advisers, voluntary agencies and advocates appointed by the courts may also be involved in safeguarding the interests of patients and clients.

20 Respect for patients' and clients' autonomy means that you should respect the choices they make concerning their own lives. Clause 5 of the code outlines your professional role in promoting patient/client independence. This means discussing with them any proposed treatment or care so that

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they can decide whether to refuse or accept that treatment or care. This information should enable the patient or client to decide what is in their own best interests.

21 Registered practitioners must respect patients' and clients' rights to take part in decisions about their care. You must use your professional judgement, often in conjunction with colleagues, to decide when a patient or client is capable of making an informed decision about his or her treatment and care. If possible, the patient or client should be able to make a choice about his or her care, even if this means that they may refuse care. You must make sure that all decisions are based on relevant knowledge. The patient's or client's right to agree to or to refuse treatment and care may change in law depending on their age and health (refer to the section on consent on pages 17–20). Particular attention to the legal position of children must be given, as their right to give consent or refuse treatment or care varies in different parts of the United Kingdom and depending on their age.

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decision you make about what information to give must be in the best interests of the patient or client.

25 There is potential for disagreement or even conflict between different professionals and relatives over giving information to a patient or client. When discussing these matters with colleagues or relatives, you must stress that your personal accountability is firstly to the patient and client. Any patient or client can feel relatively powerless when they do not have full knowledge about their care or treatment. Giving patients and clients information helps to empower them. For this reason, the importance of telling the truth cannot be over-estimated. If patients or clients do not want to know the truth, it should not be forced upon them. You must be sensitive to their needs and must make sure that your communication is effective. The patient or client must be given a choice in the matter. To deny them that choice is to deny their rights and so diminish their dignity and independence.

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Consent

26 You must obtain consent before you can give any treatment or care. The patient's or client's decision whether or not to agree to treatment must be based on adequate information so that they can make up their mind. It is important that this information is shared freely with the patient or client, in an accessible way and in appropriate circumstances. In emergency situations, where treatment is necessary to preserve life and the patient or client cannot make a decision (for example because they are unconscious), the law allows you to provide treatment without the patient's or client's consent, always acting in the best interests of the patient or client. You should also know that if the patient or client is an adult, consent from relatives is not sufficient on its own to protect you in the event of challenge, as nobody has the right to give consent on behalf of another adult.

27 When the patient or client is told about proposed treatment and care, it is important that you give the information in a sensitive and understandable way and that you give the patient or client enough time to consider it and ask questions if they wish. It is not safe to assume that the patient or client has enough knowledge, even about basic treatment, for them to make an informed choice without an explanation. You must respect the patient's or client's decision, regardless of whether he or she agrees to or refuses treatment.

28 It is essential that you give the patient or client adequate information so that he or she can make a meaningful decision. If a patient or client feels that the information they received was insufficient, they could make a complaint to the UKCC or take legal action. Most legal action is in the form of an allegation of negligence. In exceptional cases, for example where a patient's or client's consent was obtained by deception or where not enough information was given, this could result in an allegation of battery (or civil assault in Scotland). However, only in the most extreme cases is criminal law likely to be involved.

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Who should obtain consent?

29 It is important that the person proposing to perform a procedure should obtain consent, although there may be some urgent situations where another practitioner can do so. Sometimes you may not be responsible for obtaining a patient's or client's consent as, although you are caring for the patient or client, you would not actually be carrying out the procedure. However, you are often best placed to know about the emotions, concerns and views of the patient or client and may be best able to judge what information is needed so that it is understood. With this in mind, you should tell other members of the health care team if you are concerned about the patient's or client's understanding of the procedure or treatment, for example, due to language difficulties.

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Types of consent

30 Although the most important aspect of obtaining consent is providing and sharing information, the patient or client may demonstrate their decision in a number of ways. If they agree to treatment and care, they may do so verbally, in writing or by implying (by co-operating) that they agree. Equally a patient or client may withdraw or refuse consent in the same way. Verbal consent, or consent by implication, will be enough evidence in most cases. You should obtain written consent if the treatment or care is risky, lengthy or complex. This written consent stands as a record that discussions have taken place and of the patient's or client's choice. If a patient or client refuses treatment, making a written record of this is just as important. You should make sure that a summary of the discussions and decisions is placed in the patient's or client's records.

When consent is refused

31 Legally, a competent adult patient can either give or refuse consent to treatment, even if that refusal will shorten their life. Therefore you must respect the patient's refusal just as much as you would their consent. You must make sure that the patient is fully informed and, when necessary, involve other members of the health care team. As before, you should make

sure that a summary of the discussions and decisions is placed in the patient's or client's records.

32 Increasingly, the law and professional bodies are also recognising the power of advanced directives or living wills. These are documents made in advance of a particular condition arising and they show the patient's or client's treatment choices, including the decision not to accept further treatment in certain circumstances. Although not necessarily legally binding, they can provide very useful information about the wishes of a patient or client who is now unable to make a decision and therefore should be respected.

Consent of people under 16

33 If the patient or client is under the age of 16 (a minor), you must be aware of local protocols and legislation that affect their care or treatment. Consent of patients or clients under 16 is very complex, so you may need to seek local, legal or membership organisation advice. Some of the laws relating to a minor's consent have been referenced at the back of this booklet.

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Consent of people who are mentally incapacitated

34 It is important that the principles governing consent are applied just as vigorously to all forms of care with people who are mentally incapacitated as with a competent adult. A patient or client may be described as mentally incapacitated for a number of reasons. There may be temporary reasons such as sedatory medicines or longer term reasons such as mental illness, coma or unconsciousness.

35 When a patient or client is considered incapable of providing consent, or where the wishes of a mentally incapacitated patient or client appear to be contrary to the interests of that person, you should be involved in assessing their care or treatment. You should consult relevant people close to the patient or client, but respect any previous instructions the patient or client gave.

36 In some cases of legal incapacity, such as when a patient is in a persistent vegetative state, certain decisions will need court authority. Court authority may also be necessary or desirable in decisions concerning selective non-treatment of handicapped infants, dealing with certain circumstances of neonate care or sterilisation of a mentally handicapped individual.

Mental Health Acts

37 If you are involved in the care or treatment of patients or clients detained under statutory powers in the Mental Health Acts, you must get to know the circumstances and safeguards needed for providing treatment and care without consent.

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Making concerns known

38 Employers have a duty to provide the resources needed for patient and client care, but the numerous requests to the UKCC for advice on this subject indicate that the environment in which care is provided is not always adequate. You may find yourself unable to provide good care because of a lack of adequate resources. Also, you may be afraid to speak out for fear of losing your job. However, if you do not report your concerns, you may be in breach of the Code of Professional Conduct. You may also have concerns over inappropriate behaviour by a colleague and feel it necessary to make your concerns known. You will need to report your concerns to the appropriate person or authority, depending on the type of concerns. You may feel it necessary to discuss these decisions with other colleagues or a membership organisation.

39 The clauses of the code which relate specifically to these issues are numbers 11, 12 and 13:

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

40 These clauses give advice on the minimum action to be taken. This will help to make sure that those who manage resources and staff have all the

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information they need to provide an adequate and appropriate standard of care. You must not be deterred from reporting your concerns, even if you believe that resources are not available or that no action will be taken. You should make your report verbally and/or in writing and, where available, follow local procedures. The manager (who may also be registered with us) should assess the report and communicate it to senior managers where appropriate. This is important because if, subsequently, any complaint is made about the registered practitioners involved in providing care, this may require senior managers to justify their actions if inadequate resources are seen to affect the situation.

41 As outlined in clauses 11, 12 and 13 of the code, the registered practitioner's role is to make sure that safe and appropriate care is provided. This means:

- promoting staff support throughout health care settings;
- telling senior colleagues about unacceptable standards;
- supporting and advising colleagues at risk;
- reporting circumstances in the environment which could jeopardise standards of practice;
- making sure that local procedures are in place, challenged and/or changed;
- being aware of new codes, charters and registration body guidelines;
- keeping accurate records and
- when necessary, obtaining guidance on how to present information to management.

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ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST

DIRECTORATE OF CLINICAL SUPPORT SERVICES

PATIENT'S CASENOTES STANDARDS

The following standards were agreed by the Hospital Management Team at its meeting on 14 May 1996 and reaffirmed at its meeting in September 1997.

1. Only one set of casenotes should exist for each patient (exception - Maternity Notes)

2. The cover of all casenotes must be intact and clearly marked to identify the patient. Any known allergies must also be clearly written on the front cover.

3. Handwriting on notes should be in dark ink to facilitate legibility, photocopying and miniaturisation.

4. The date and time of every note must be shown.

5. The name of the person signing the notes must be printed underneath the signature. (HIGHLY RECOMMENDED)

6. Only approved hospital abbreviations should be used. 'Left' and 'Right' must always be written in full. Digits must be named not numbered.

7. Medical or nursing notes must never be erased, over-written or inked out. Errors must be scored out with a single line and the corrected entry written alongside with the date, time, signature and name printed. Correction fluid must not be used.

8. Any additions must be separately dated, timed and signed.

9. No personal comments must be made in the patients casenotes.

10. Typed notes and all hospital correspondence must be checked and signed by the doctor who dictates them. Any corrections to correspondence must be made on all copies or the correspondence re-typed.

11. Request forms (pathology, x-ray, etc.) must have an addressograph label attached to identify the patient and include appropriate previous history, the ward/department, and the name of the Consultant. These forms must be signed and dated by the requesting authorised practitioner.

12. All results must be reviewed and initialled by a Clinician (and appropriate action taken) before being filed in the patient's records.

13. All prescriptions must be printed in black ink, and be legible, dated and signed. Instructions regarding discontinued drugs must be dated and signed by the doctor.

S M DUNNE
May 1996
Reissued June 1998