NHS
Greater Glasgow and Clyde

Making a Difference

Management Programme for Staff Nurses and Staff Midwives

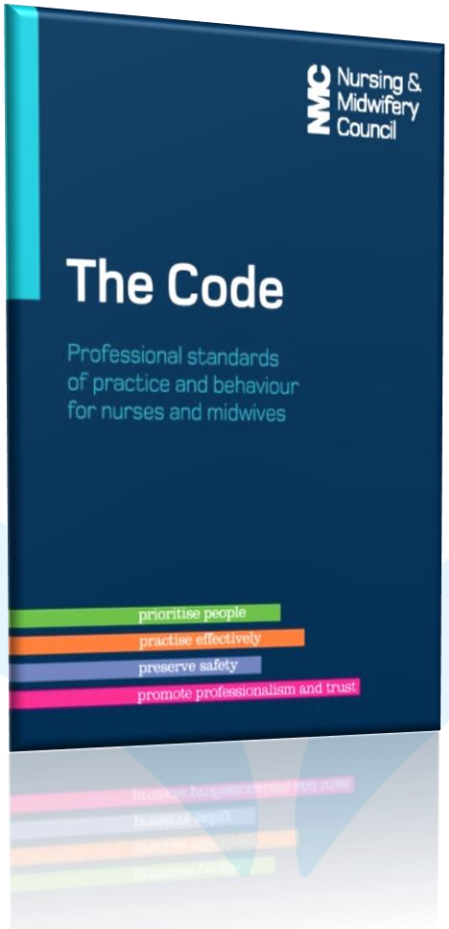
"The hand that touches the patient, makes a difference."

Dr. Margaret Maher McGuire

Professionalism and Record Keeping

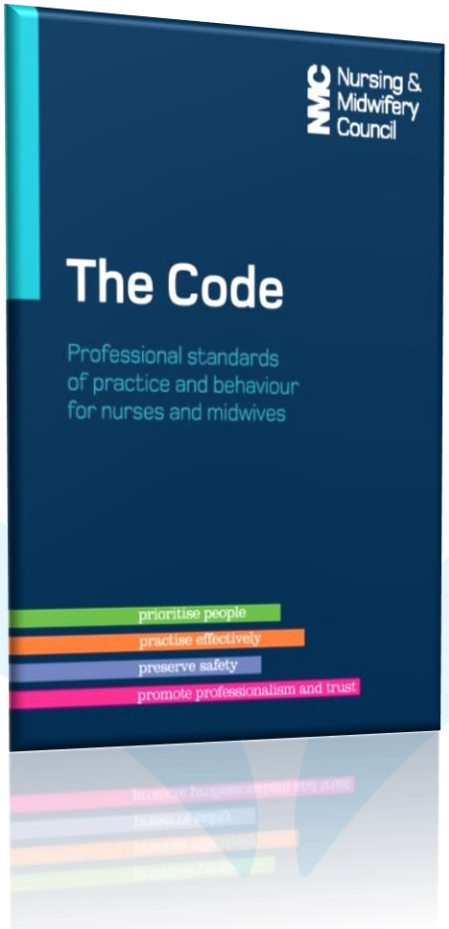
The Code

For everyone's protection



The Code

The Code of professional standards sets out the universal standards expected of nurses and midwives that they must uphold in order to be registered to practise in the UK.



Do you know your Code?

Please note the letter which you think is the correct answer:

The Code can be used by:

A – patients and service user
B- employers
C- educators
D – All of above

The code was revised in response to:

A – media and government pressure
B- Francis report recommendations
C- NMC reorganisation
D- All of above

The role of the NMC is:

A- T o ensure your employer supports revalidation
B- To ensure nurses and midwives keep their skills and knowledge up to date and up hold professional standards
C- To manage practice concerns relating to nurses and midwives.
D- All of above

The over arching theme of the new code is:

A- Public protection
B- Practise effectively
C- Preserve safety
D- Prioritise people

New additions to the code include:

A- Duty of candour
B- Use of social media
C- Standards for fundamentals of care
D- All of above

Who needs to know about the Code?

- Every one of the 680,000 plus nurses and midwives registered with the NMC is required to uphold the new Code.
- In addition, the Code is relevant to a range of other groups who have day to day contact with nurses and midwives, including:
  - Employers
  - Educators
  - Students
  - Patients and service users
  - General public
  - Unions and professional bodies
  - Other regulators and policy
  - makers

The Code

One Code, four themes – what are the 4 Ps?

Together they signify good nursing and midwifery practice with the ultimate aim of public protection.

The Code – did you get it right?

Prioritise people

Treat people as individuals and uphold their dignity

Practise effectively

Always practice in line with the best available evidence

Preserve safety

Only act in an emergency within the limits of your knowledge and competence

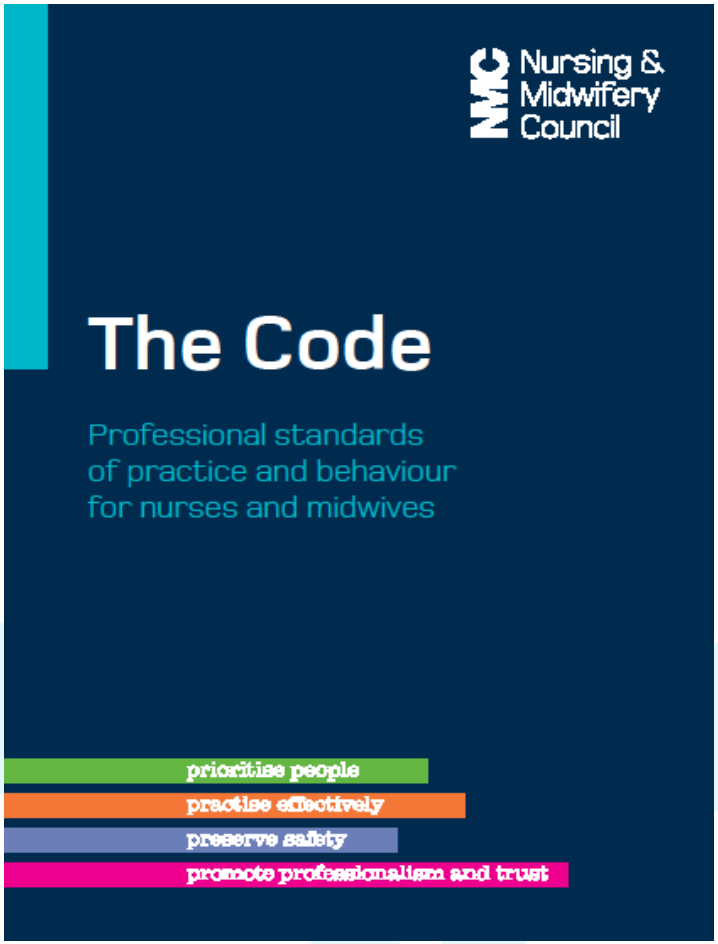
Promote professionalism and trust

Fulfil all Registration requirements

NMC Code

Making The Code central to practice

- Professional nurse meetings - agenda items aligned to the Code
- Questions on the Code are embedded into nurse /midwife interviews
- Keep a copy on your ward /clinical area



Key Points in the Code?

Duty of Candour

Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause harm or distress.

Social media

The Code recognises the changing nature of communications and sets standards for acting responsibly, including the use of social media.

Fundamentals of care

The Code sets standards of fundamental care and provides examples of what this includes such as nutrition, hydration and environmental cleanliness.

Key Points in the Code?

Medicines management and prescribing
Standards that clearly set the context for prescribing, supply, dispensing and administering medications.

Conscientious objection
Nurses and midwives must act in the best interests of people at all times and can only make conscientious objections to a particular procedure in limited circumstances.

End of life care
Specific reference is made to the needs of those in the last days and hours of life.

Key Points in the Code?

A greater focus on:

Compassionate care – kindness, respect and compassion

Teamwork – work co-operatively

Record keeping – six clear standards to support all record keeping

Delegation and accountability – delegate responsibly, be accountable

Raising concerns – this aligns the Code with the re-launched *Raising Concerns Guidance* published in 2013

Cooperating with investigations and audits – including those against individuals or organisations, and cooperating with requests to act as a witness at hearings.

NHSGGC Nursing/AHP Uniform

Key Points to be followed.

The aim of the Staff Uniform & Dress Policy is to provide a unified approach across NHSGGC.

All nursing/AHP staff must adhere to the Staff Uniform and Dress Policy.

The Policy is designed to link with the NHSGGC Infection Prevention & Control (IPC) and Health & Safety practices and policies.

The Policy statement for Health Care Workers (HCWs) states,

'HCWs must wear a uniform when working in an area where a uniform is designated by management.'

Nursing/AHP staff must wear a uniform when working or visiting a clinical environment, the uniform must be appropriate for their grade.

The personal use of mobile phones is prohibited when working in all clinical areas.

Uniform

Uniforms must be clean and changed on a daily basis. Where there are signs of wear or stains that cannot be removed the uniform must be returned and a new uniform obtained.

Uniforms must be of the correct size, trouser hems should be stitched, must not touch the floor and the tunic must fit properly.

Where NHS cardigans or an NHS fleece has been issued they must not be worn within the clinical area when attending to a patient.

The **nurse in charge** must wear a **red name badge** to identify name and position of being the person in charge. All staff must wear the yellow 'my name is' badge.

Footwear

- Flat shoes or trainers with discreet markings are acceptable.
- Footwear should fully enclose the foot, have no perforations, no heel straps and be a non penetrable fabric.
- Staff **must not wear** 'Crocs'

Jewellery

- No wrist watches
- No jewellery to be worn except a plain wedding band

Nails/cosmetics/ perfume & aftershave

- Nails must be kept clean, tips must be short and without nail varnish, artificial fingernails or nail extensions.
- Perfume /after shave must be discreet
- Nursing/AHP staff must ensure a high standard of personal hygiene

Hair/ Eyelashes

- Hair must be clear and off the face. If it touches the collar, hair must be neatly tied up to keep it clear.
- Extremes of fashion with regards to hair colour & style should be avoided.
- False eyelashes should not be worn in the clinical area.

288538

Breaching of the Code

The Telegraph

HOME » NEWS » HEALTH

Facebook nurse banned for inappropriate postings

A nurse has been banned from working for six months for posting a series of "wholly inappropriate" things on Facebook - including a photograph of a colleague sitting on a bedpan.

The Council's solicitor Tim Horder said: "An investigation found 45 Facebook pages with frequent sexual references, references to drinking and derogatory postings about her workplace and her job. Nurses have to uphold a reputation of professionalism at all times.

"These are comments a proper nurse would not have made in front of parents of patients and the fact they were made in public on a networking site amounts to the same thing."

Find the Article Here

Types of Health Records

- Personal Health Records (paper and electronic) including end of bed documentation/care plans/ prescription kardexes
- Complaint and Incident files
- Images e.g. X-ray and imaging reports/photographs
- Audio and video tapes (analogue and digital)
- IT systems – Trakcare/Ward View/Clinical Portal/email etc.
- Material intended for short-term or transitory use, including daily hand over notes and ‘spare copies’ of documents

Principles of good record keeping

- Provide clear and concise evidence of planned care
- Entries should be signed and printed with name and designation
- Date and time each entry as soon as possible after care given
- Legible, accurate and factual
- Written in black ink which cannot be erased or deleted
- Records should never be tampered with or falsified
- Alterations should be signed and dated

Scenarios

- Assign a note taker and feed-back person in each group
- Consider your scenario under the themes of the code
- Identify areas of poor practice and suggest how the scenario could have a different outcome
- 20 minutes to discuss & prepare feedback

Scenario 1

- Mrs A, 80 yrs old lady was given a phosphate enema in error; the enema was not prescribed. The patient in the next bed, Mrs B should have received an enema in preparation for a procedure that morning. Consequently Mrs B's surgical procedure was delayed until she had had appropriate bowel preparation.
- Mrs A had episodes of loose stools throughout the day. She was distressed and could not understand why she had been given the enema. Mrs A says she questioned the nurse as to why she needed an enema and was assured that she needed it, no further explanation or reasons offered.
- Mrs A became confused and disorientated over the next 24 hours which caused great concern and distress to both her and her family, as she is not normally cognitively impaired.
- The registered nurse who administered the enema, who was employed on the nurse bank mentioned numerous times to her colleagues that this was her fifth 12 hour night shift in a row.

Scenario 2

- On 13th July the complaints department received a formal complaint from Mrs Brown whose husband had recently been a patient in the surgical ward, looked after by Staff Nurse McD. Mrs Brown raised specific concerns about Staff Nurse McD and advised that her husband had referred SN McD to the NMC in relation to the same episode of care.
- Mrs Brown states in her letter that her husband had been transferred between two hospitals just before 13.00hrs. She said that despite being in severe pain he was moved from trolley to bed without the use of a pat slide. On review of nursing notes the nursing care plan was not up to date prior to transfer and was not updated following admission to the surgical ward. The first entry following transfer reads “patient transferred to ward encouraged to mobilise from trolley to bed. Catheter patent, volumes good”.
- In her letter Mrs Brown went on to describe her husband being in severe pain. According to the nursing records at 14.00hrs Mr Brown’s pain score was 1, indicating that he had no pain at rest however SN McD made an entry in the nursing notes at 15.00hrs indicating that he had been reviewed by the FY1 and had been “given sevredol 10mg for pain and started on diazepam”. The next entry at 19.00hrs read “IV amoxicillin given as charted”.
- Mrs Brown found her husband to be very distressed from this ordeal. She described him as a quietly spoken 41 years old man who was cooperative and reasonable. She said she sat with him whilst her son spoke to SN McD at the nurses’ station. All she could hear was a loud, aggressive, angry conversation. Because of this she joined them and said there was nothing friendly or compassionate about her.
- The family spoke to a senior doctor and expressed concerns about SN McD’s manner, describing her as “fierce” and were worried that Mr Brown may be harmed in her care.
-

Scenario 3

- Mr A was admitted to hospital after collapsing at the shops. He was found to have mild left hemiparesis and a CT scan of his head showed an increase in size of a pre-existing tumour. He underwent a posterior fossa craniotomy and de-bulking of a very vascular tumour. He had a stormy post-operative recovery; periods of atrial fibrillation, hypotension, pyrexia and hypoxia, culminating in a peri-arrest.
- One night in HDU there were three Registered Nurses and one Health Care Support Worker on duty. There were six patients in HDU divided between two rooms; three patients in each. Mr B, who was not in the same room as Mr A, required to have active nursing care every two hours requiring four members of staff for positional changes due to his size. This meant that additional help was needed to look after Mr A and the other two patients when nursing staff were assisting Mr B.
- Staff Nurse C and Staff Nurse D were responsible for Mr A and another two patients in Room 1.
- Shortly before 23.00 hours Staff Nurse E asked for help to reposition Mr B in Room 2 meaning all four members of staff on duty were in Room 2, leaving no staff in Room 1 with Mr A.
- Just as they were finishing up in Room 2 a loud bang was heard coming from Room 1. Upon entering the room Staff Nurse C found Mr A lying on the floor, face down next to his bed. His bed was low to the floor and the bed rails were up. Staff Nurse C and Staff Nurse D helped him to a seating position on the floor and reassured him. They stayed with him whilst Staff Nurse E called the doctor and then went to get a hoist.
- He was complaining of chest pain, his skin was clammy and his abdomen was cyanosed. He had a laceration to the bridge of his nose and there was a small pool of cerebrospinal fluid on the floor as his extraventricular drain had become disconnected during the fall. He was hypoxic; oxygen saturation was 80-85, pulse 150/min and irregular, blood pressure 122/80. Following medical review, further bloods were taken and a chest x-ray was performed, which showed a left pneumothorax.
- On reviewing nursing records the following documents were incomplete;
- · Falls risk assessment
- · Bed rails assessment
- · Risk assessment for the management of patients with challenging behaviour

Scenario 4

- 6th Oct

- Dave appears upset this morning and was reluctant to have his dressing changed. Dave was complaining of a temperature and was advised to take 2 paracetamol (500mgs) every 4 hours. Wound swab taken. Next visit for 7th October.

- Signed : AC Davies

Scenario 5

- **Incident**: Patient within ward fell
- **Circumstances**: Patient fell due to a faulty catch on cot side. Patient fractured femur.
- **What Happened next**: Following the incident, the nurse reacted appropriately and the patient was cared for in an appropriate manner – assessment, medical examination etc.,
- **Complaint**: Patient's relative lodges a complaint with the trust. At the interview, the nurse gives a full and true account of the situation. As part of the complaint process, the patient's records are examined to complement the interview. However, as the priority had been to make sure that the patient received medical attention, the nurse had neglected to complete the records with the appropriate detail – this was identified in the nurse's statement.
- **Outcome**: the nurse is discredited as a professional. A consideration of her account given during her statement was deemed inaccurate as it was not supported in the documentary evidence.
- **Additional circumstances**: on the day of the incident, the patient fell at 2.50pm. When the nurse's shift finished at 3.15pm, she had a personal commitment to collect her children from school – she did not take sufficient time to complete her documentation.

Scenarios Feedback

Avoid…

- Unnecessary professional jargon
- Irrelevant speculation
- Subjective statements or value judgements
- Remarks which might be construed as offensive

What to avoid

Professional jargon: –

- 83 yr old lady for IVF, patient 4F&D or FF, FFM result = B9 tumour.....can you translate?
- turns out this is not fertility treatment (IVF) but intravenous infusions, 4F&D = for fluids and diet, FF= Free Fluids & FFM =Fast from Midnight, B9 = Benign tumour

BUT.....

Some acceptable abbreviations – PUDRA for example

Delegation of record keeping

It is the responsibility of the professional to ensure that this is delegated effectively i.e. establish that anyone you delegate to is able to carry out your instructions and confirm that the outcome of any delegated task meets required standards

(NHSGGC 2012)

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - NURSING

Date & Time		Signature, Print Name & Designation
	~~did not actually fall.~~	
	was not seen falling but was found on the	
	floor despite being told not to try to walk	
	on her own	J. SMITH SIN
13-B-13	Settled night, ü caused	
N.B.	no disruption in ward	Student nurse.
08/04/16	Obs Stable. All care given. offering	L Brown.
1810	no complaints	K Smith RGN
	Care continues as planned.	
	Tolerating diet and fluids, one	
	episode of vomiting but uncomplaining	
1930	Observations recorded as charted,	
	fluid balance chart discontinued	
	Pleasantly disorientated with	
	frequent visits to toilet area.	

Record of Communication with Relatives / Carers

NHS Greater Glasgow and Clyde

This form should be stored at the front of the patient's nursing notes during the period of admission and then filed on discharge.

Hospital:	Ward:

Name: .....

Address: .....

.....

DoB: .....

Chi number: .....

Affix patient data label

Please enter date of communication and topic (all entries must be signed and dated)

Date & Time	Full record of source; Topic of discussion; Name of relative/carer	Signed	Staff Code
6/6	Spoke to patient's daughter this evening. She is finding it increasingly difficult looking after her mum at home	JM	N
	Patient's son complaining his mum has been moved 3 times and feels this isn't helping her dementia. I told him we can't do anything about the bed shortage!!		

Poorly completed food chart

FOOD RECORD CHART

Department of Nutrition & Dietetics

Name: A N OTHER

Ward:

Date commenced: 5/7/15

- Please record ALL food and drinks taken.
- Use handy measures such as 1 cup, ½ bowl etc.
- State if patient has refused food or drinks.
- If intake is ½ or less than ½ of normal hospital meals after 3 days, consider referral to the Dietitian for further assessment.

DAY	BREAKFAST	MID-MORNING	LUNCH	MID-AFTERNOON	EVENING MEAL	SUPPER	NURSING OR DIETETIC COMMENTS
5/7	Bread + Jam Tea		Omelette. (part)		Mince + potatoes pudding (part)	Toast x1	
6/7	Porridge (part) Refused tea					Toast x1	
7/8	Wheetabix and milk Tea		refused	Out with daughter	refused (as had lunch out)	Toast x1	OVER

Well completed food chart

EXAMPLE (2)

FOOD RECORD CHART

Department of Nutrition & Dietetics

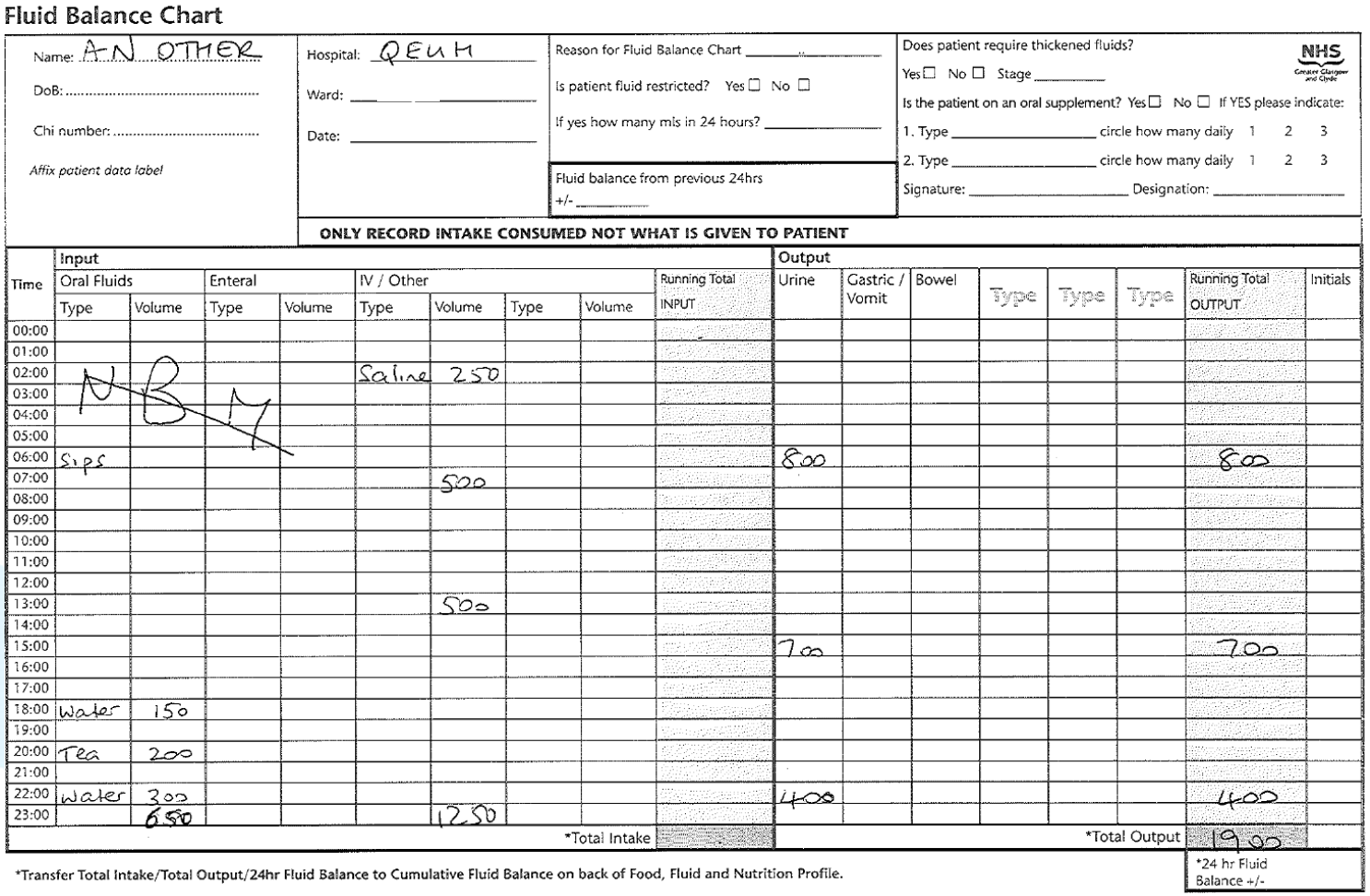
A. N. OTHER

Commenced: 5/7/15

- Please record ALL food and drinks taken.
- Use handy measures such as 1 cup, ½ bowl etc.
- State if patient has refused food or drinks.
- If intake is ½ or less than ½ of normal hospital meals after 3 days, consider referral to the Dietitian for further assessment.

BREAKFAST	MID-MORNING	LUNCH	MID-AFTERNOON	EVENING MEAL	SUPPER	NURSING OR DIETETIC COMMENTS
1 Slice brown bread, butter & Jam Ate all Tea with milk	x2 biscuits Tea All	1 cheese omelette with pea ½ eaten	1 crumpet with jam Tea	Mince ½ Potatoes ⅓ Carrots ½ Ginger Sponge + Custard ½	Toast x 1 butter Horlicks	Managing lighter meals Smaller portions
½ bowl porridge 200mls FF Milk	Patient refused biscuits Tea with milk	Baked Pot with Tuna Ate ½	½ Scone with Jam Tea with milk	Fish in Parsley Sauce All Mashed Pot ½ Turnip All	Brown bread toast x1 with butter Hot Choc	As Above
1 Weetabix Sugar 200mls FF milk	Crumpet with butter + Jam	Off ward for Lunch Pt refused Sandwich will have something with daughter	M&S prawn sandwich Ate All Iced Tea Cake Tea with milk	Patient refused	Toast x 2 with butter + Jam Tea with milk	Ate well with family today. OVER

Poorly completed fluid balance chart



Fluid Balance Chart

Name: AN OTHER
DoB: .....
Chi number: .....
Affix patient data label

Hospital: QEUH
Ward: _____
Date: _____

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total INPUT	Output						Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00					Saline	250											
03:00																	
04:00																	
05:00																	
06:00	Sips									800						800	
07:00						500											
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00						500											
14:00																	
15:00										700						700	
16:00																	
17:00																	
18:00	Water	150															
19:00																	
20:00	Tea	200															
21:00																	
22:00	Water	300								400						400	
23:00		650				1250											
								*Total Intake							*Total Output	1900	

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

Well completed fluid balance chart

EXAMPLE (2)

Balance Chart

ne: A N OTHER
:
number:
patient data label

Hospital: QEUH
Ward:
Date: 12/7/15

Reason for Fluid Balance Chart NBM IVfluids
Is patient fluid restricted? Yes ☐ No ☑
If yes how many mls in 24 hours? —

Fluid balance from previous 24hrs
+/- +150mls

Does patient require thickened fluids?
Yes ☐ No ☑ Stage
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type ____ circle how many daily 1 2 3
2. Type ____ circle how many daily 1 2 3
Signature: Elsrdn Designation: SIN

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Input									Output							
Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
				Nacl	250			250								EG
SIPS	10							260								EG
									800						800	EG
					500			760								EG
Meds	50							810								EG
					500			1310								EG
									700						1500	
					500			1810								EG
Water	150			IV fluids discontinued				1960								EG
Tea	200							2160								EG
Water	300							2460	400						1900	EG
							*Total Intake	2460						*Total Output	1900	EG

*24 hr Fluid Balance +/- +560

er Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

When is your record keeping under scrutiny?

- in response to a complaint
- a police investigation
- an NMC enquiry
- a public enquiry
- a fatal accident enquiry

Poor record keeping and NMC

- Registered midwife charged with omitting information:
  - Did not document on patients maternity progress sheet, postnatal chart and fluid balance chart
  - Did not record foetal heart rate with sufficient regularity
  - Did not document a discussion with patient
- Fitness to practise is impaired by reason of misconduct