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Code C

As promised copies of the old UKCC Codes, there are others around, but these are the main ones. Now all replaced by NMC Codes. These were in place in 1991 but updated on dates printed on them.

Sorry about alterations
on statement.

Hope its ok.

Code C

Standards for Records and Record Keeping

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

April 1993

List of Contents

Introduction

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

1.1 impairing continuity of care;

1.2 introducing discontinuity of communication between staff;

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

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

1.5 failing to place on record significant observations and conclusions.

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

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

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

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

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

The Purpose of Records

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

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

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

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

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

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

4.6 support standard setting, quality assessment and audit and

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

The Importance of Records

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

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

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

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

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

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

Standards for Records - Key Features

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

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

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

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

6.4 aid patient or client involvement in their own care;

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

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

Standards for Records - Ethical Aspects

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

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

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

Standards for Records - Recording Decisions on Resuscitation

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

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

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

Standards for Records - Essential Elements

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

13.1 be written legibly and indelibly;

13.2 be clear and unambiguous;

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

13.4 ensure that alterations are made

by scoring out with a single line followed by the initialled, dated and timed correct entry;

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

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

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

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

14 In summary, the record:

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

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

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

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

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

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

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

19 The making of entries will be organised so that:

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

19.2 the plan and other records complement each other.

20 The practitioner, in applying the process and using the plan, will

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

The Legal Status of Records and Its Implications

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

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

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

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

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

22.4 a record of the arrangements

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

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

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

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

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

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

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

Retention of Obstetric Records

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

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

Patient or Client Held Records

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

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

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

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

Patient or Client Access to Records

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

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

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

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

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

Shared Records

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

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

Computer Held Records

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

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

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

The Practitioner's Accountability for Entries Made by Others

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

Summary of the Principles Underpinning Records and Record Keeping

41 The following principles must apply:

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

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

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

41.4 the record is clear and unambiguous;

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

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

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

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

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

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

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

References

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

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

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

23 Portland Place, London W1N 3AF
Telephone 0171-637 7181 Facsimile 0171-436 2924

Protecting the public

UKCC

Protecting the public through professional standards

Last time you visited your local hospital, maternity unit or health centre, did you stop for a moment to think about the nurse, midwife or health visitor who was caring for you, your family member or your friend? How do you know that they know what they are doing? How do you know that they are properly prepared? How do you know that they are safe to care for you? What makes a registered nurse, midwife or health visitor different from a care assistant or a support worker?

Nurses, midwives and health visitors are educated to high professional standards in order to provide quality care. These are set out in their *Code of professional conduct*, published by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), which sets standards for the three professions. The UKCC's role is to protect patients by promoting high standards of professional education, practice and conduct. When a nurse, midwife or health visitor falls short of these standards, we have the power to remove them from the register in order to protect patients.

How does the UKCC protect patients?

We protect patients by:

- setting standards for nursing, midwifery and health visiting education, practice and conduct
- maintaining a register of qualified nurses, midwives and health visitors
- providing advice for nurses, midwives and health visitors on professional standards
- considering complaints about professional misconduct or unfitness to practise due to serious ill health and taking action against those who are found guilty of misconduct or who are not fit to practise.

This means you can be assured that the registered nurses, midwives and health visitors who are caring for you are properly qualified and have high standards of professional practice and conduct.

The Council

The UKCC has a governing Council of 40 elected nurse, midwife and health visitor members and 20 members who are appointed in the public interest by the Secretary of State for Health. The appointed members include representatives of patients' organisations. This means that the Council's membership is accountable to the public as well as to the registered nurses, midwives and health visitors whose registration fees fund our work. The elected members represent all parts of the United Kingdom and the three professions. The Council meets quarterly and its meetings are open to the public.

Public protection and professional standards

The UKCC ensures safe practice by nurses, midwives and health visitors by developing and promoting professional standards. We provide further public protection through our professional conduct work. On rare occasions, nurses, midwives and health visitors fall short of the standards expected of them. When a complaint is made, we investigate it thoroughly and fairly. Anyone can make a complaint about the professional conduct of a nurse, midwife or health visitor. Information about how to make a complaint and what details we will need in order to investigate it are available in a booklet from the UKCC.

When a complaint has been investigated and found to be serious enough to warrant removal from the register, the nurse, midwife or health visitor will be called to appear before our Professional Conduct Committee. These hearings are also open to the public and they are held across the United Kingdom. If you would like to attend, please call 0171 333 6572 for details of dates and venues. Where misconduct is proven, the committee has the power to remove the practitioner's name from the register. We try to strike a balance between protecting the public and being fair to those who are called before the committee. Where there is any doubt, however, the committee always puts the protection of patients first.

When a practitioner is removed from the register, the UKCC automatically notifies employers of nurses, midwives and health visitors. Employers and members of the public can check full details of a practitioner's education, qualifications and registration status through a telephone helpline on 0171 631 3200. They can therefore be certain that the individual whom they wish to employ is safe to care for patients.

As a further guarantee of public protection, we take action against the small number of individuals who falsely claim to be registered nurses, midwives or health visitors. It is a criminal offence to do this and we ensure that those who knowingly make such false claims are prosecuted.

How is the public involved in the UKCC's work?

The UKCC has strong links with organisations representing patients. Three of our Council members and many of our committee members represent patients' organisations. We hold an annual conference with these organisations so that we can listen to their views and explain how we help to protect patients. Patients' representatives sit on the committees which consider complaints about professional conduct and we have recently increased the numbers of patients' representatives who are available to the committees. In this way, patients can influence everything that the UKCC does to protect them.

Facts and figures

There are over 640 000 nurses, midwives and health visitors on our register. The UKCC handles:

- about 5 000 telephone calls every working day
- up to 15 000 items of post every working day
- about 2 000 changes to the register every working day
- around 900 complaints a year from the public, employers and practitioners about possible professional misconduct by registered nurses, midwives and health visitors.

Who pays for protecting patients?

We rely almost exclusively on the registration fees of £1 a month paid by nurses, midwives and health visitors for our income. We receive no public money from the government or any other source.

How can I contact the UKCC?

Our telephone lines are open from 8.00 am and many sections are staffed from then until 6.00 pm. Our main switchboard number is 0171 637 7181.

Direct dial numbers include:

Registration enquiries	0171 333 9333
Professional conduct	0171 333 6564
Public enquiries	0171 333 6690
UKCC fax number	0171 436 2924

July 1997

Protecting the public through professional standards

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

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Protecting the public
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United Kingdom Central Council for Nursing, Midwifery and Health Visiting

EXERCISING ACCOUNTABILITY

A framework to assist nurses, midwives and health visitors to consider ethical aspects of professional practice.

UKCC

A UKCC Advisory Document

EXERCISING ACCOUNTABILITY

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A framework to assist nurses, midwives and health visitors to consider ethical aspects of professional practice.

This is the 4th document in a series to supplement the Code of Professional Conduct for the Nurse, Midwife and Health Visitor. (Second Edition; November 1984).

In the text that follows the use of the feminine gender equally implies the male and similarly the use of the male gender equally implies the female.

The word "Practitioner" in this document means a registered nurse, midwife or health visitor. Where reference is made to a practitioner from another profession it is indicated by the relevant prefix.

The contents of this Advisory Paper are relevant to all persons whose names appear on any part of the Professional Register maintained by the UKCC and will be of special interest to those undertaking courses of education and training with a view to admission to the Register.

In order to understand fully the issues addressed it is essential that the advisory paper should be read in its entirety.

CONTENTS

A. Introduction

1. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting regulates the nursing, midwifery and health visiting professions in the public interest.

The UKCC was established by the Nurses, Midwives and Health Visitors Act 1979.

Section 2(1) of the Nurses, Midwives and Health Visitors Act 1979 states that **'The principal functions of the Central Council shall be to establish and improve standards of training and professional conduct'**.

Section 2(5) of the same Act moves from the requirement to improve conduct to one of the methods to be employed when it states that **'The powers of the Council shall include that of providing in such manner as it thinks fit, advice for nurses, midwives and health visitors on standards of professional conduct'**.

2. The Code of Professional Conduct for the Nurse, Midwife and Health Visitor is the Council's definitive advice on professional conduct to its practitioners. In this extremely important document practitioners on the UKCC's register find a clear and unequivocal statement as to what their regulatory body expects of them. It therefore also provides the backcloth against which any alleged misconduct on their part will be judged.

The Code of Professional Conduct is considered to be

a statement to the profession of the primacy of the interests of the patient or client.

a statement of the profession's values.

a portrait of the practitioner which the Council believes to be needed and which the Council wishes to see within the profession.

3. The Council has already published three advisory documents to supplement the Code of Professional Conduct. Practitioners now seek:

(i) elaboration of clauses 10 & 11 of the Code and support for their position when doing as these clauses require. These Clauses state that:–

'Each registered nurse, midwife and health visitor is accountable for his or her practice and, in the exercise of professional accountability, shall:–

10. Have regard to the environment of care and its physical, psychological and social effects on patients/clients, and also to the adequacy of resources, and make known to appropriate persons or authorities any circumstances which could place patients/clients in jeopardy

or which militate against safe standards of practice.

11. Have regard to the workload of and the pressures on professional colleagues and subordinates and take appropriate action if these are seen to be such as to constitute abuse of the individual practitioner and/or to jeopardise safe standards of practice'.

(ii) advice and guidance on issues related to consent and the general subject of truth telling.

(iii) advice and guidance on that part of the practitioner's role which concerns advocacy on behalf of patients and clients.

(iv) elaboration of clause 5 of the Code which states that each registered nurse, midwife and health visitor shall:

5. 'Work in a collaborative and co-operative manner with other health care professionals and recognise and respect their particular contributions within the health care team'.

(v) advice and guidance on issue related to contentious treatments and conscientious objection.

This document provides a response to those requests, aims to assist professional practitioners to exercise their judgement and reinforces the importance of the Code of Professional Conduct.

B. The Code of Professional Conduct and the subject of accountability

1. This new UKCC advisory document has been produced in order to establish more clearly the extent of accountability of registered nurses, midwives and health visitors and to assist them in the exercise of professional accountability in order to achieve high standards of professional practice.

2. The Code begins with an unequivocal statement **'Each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to justify public trust and confidence, to uphold and enhance the good standing and reputation of the profession, to serve the interests of society, and above all to safeguard the interests of individual patients and clients'.**

This introductory clause indicates that a registered practitioner is accountable for her actions as a professional at all times, whether engaged in current practice or not and whether on or off duty.

In situations where the practitioner is employed she will be accountable to the employer for providing a service which she is employed to provide and for the proper use of the resources made available by the employer for this purpose.

In the circumstances described in the preceding two paragraphs the practitioner has an ultimate accountability to the UKCC for any failure to satisfy the requirements of the introductory paragraph of the Code of Professional Conduct.

The words 'accountable' and 'accountability' each occur only once in the Code, both being found in the stem paragraph out of which the subsequent 14 clauses grow. They do, however, provide its central focus as the Code is built upon the expectation that practitioners will conduct themselves in the manner it describes.

3. Accountability is an integral part of professional practice, since, in the course of that practice, the practitioner has to make judgements in a wide variety of circumstances and be answerable for those judgements. The Code of Professional Conduct does not seek to state all the circumstances in which accountability has to be exercised, but to state important principles.

The primacy of the interests of the public and patient or client provide the first theme of the Code and establish the point that, in determining his or her approach to professional practice, the individual nurse, midwife or health visitor should recognise that the interests of public

and patient must predominate over those of practitioner and profession. The second major theme is the exercise by each practitioner of personal professional accountability in such a manner as to respect the primacy of those interests.

4. The Code of Professional Conduct states unequivocally that all practitioners who are registered on the UKCC's register are required to seek to set and achieve high standards and thereby to honour the requirement of **Clause 1 of the Code** which states that each registered nurse, midwife and health visitor shall:–

1. **'Act always in such a way as to promote and safeguard the wellbeing and interests of patients and clients'.**

It is recognised that, in many situations in which practitioners practice, there may be a tension between the maintenance of standards and the availability or use of resources. It is essential, however, that the profession, both through its regulatory body (the UKCC) and its individual practitioners, adheres to its desire to enhance standards and to achieve high standards rather than to simply accept minimum standards. Practitioners must seek remedies in those situations where factors in the environment obstruct the achievement of high standards: to start from a compromise position and silently to tolerate poor standards is to act in a manner contrary to the interests of patients or clients, and thus renege on personal professional accountability.

C. Concern in respect of the environment of care

1. The dilemma for practitioners in many settings in respect of the environment of care is very real and has been well documented. If practitioners express concern at the situations which obstruct the achievement of satisfactory standards they risk censure from their employers. On the other hand, failure to make concerns known renders practitioners vulnerable to complaint to their regulatory body (the UKCC) for failing to satisfy its standards and places their registration status in jeopardy.

The sections of the Code of Professional Conduct that are particularly relevant to this issue are the introductory paragraphs and clauses numbered 1, 2, 3, 10 & 11. **These parts of the Code apply to each and every person on the Council's register. Whether engaged in direct care of the patient or client, or further removed but in a position to exert influence over the setting in which that contact exists, the practitioner is subject to the Code and has an accountability for her actions or omissions.**

2. The import of the Sections of the Code referred to is that, having, as part of her professional accountability, the responsiblity to **'serve the interests of society and above all to safeguard the interests of individual patients and clients'** and to **'act always in such a way as to promote and safeguard the wellbeing and interests of patients/clients'**, the registered nurse, midwife and health visitor must make appropriate representations about the environment of care:–

(a) where patients or clients seem likely to be placed in jeopardy and/or standards of practice endangered;

(b) where the staff in such settings are at risk because of the pressure of work and/or inadequacy of resources (which again places patients at risk);

and

(c) where valuable resources are being used inappropriately.

This is an essential part of the communication process that should operate in any facility providing health care, to ensure that those who determine, manage and allocate resources do so with full knowledge of the consequences for the achievement of satisfactory standards. Nurses, midwives and health visitors in management positions should ensure that all relevant information on standards of practice is obtained and communicated with others involved in health policy and management in the interests of standards and safety.

3. Practitioners engaged in direct patient or client care should not be deterred from making representations of their concerns regarding the environment of care simply because they believe that resources are unavailable or that action will not result. The immediate professional manager to whom such information is given, having assessed that information, should ensure that it is communicated to more senior professional managers. This is important in order that, should complaints be made about the practitioners involved in delivering care, the immediate and senior managers will be able to confirm that the perceived inadequacies in the environment of care have been drawn to their attention.

It is clearly wrong for any practitioner to pretend to be coping with the workload, to delude herself into the conviction that things are better than they really are, to aid and abet the abuse and breakdown of a colleague, or to tolerate in silence any matters in her work setting that place patients at risk, jeopardise standards of practice, or deny patients privacy and dignity.

In summary, Section C of this document simply restates the UKCC's expectations (set out in the Code of Professional Conduct) that while accepting their responsibilities and doing their best to fulfil them, practitioners on its register will ensure that the reality of their clinical environment and practice is made known to and understood by appropriate persons or authorities, doing this as an expression of their personal professional accountability exercised in the public interest. An essential part of this process is the making of contemporaneous and accurate records of the consequences for patients and clients if they have not been given the care they required.

4. **The Code of Professional Conduct applies to all persons on the Council's register irrespective of the post held. Their perspective will vary with their role, but they share the overall responsibility for care. No practitioner will find support in the Code or from the UKCC for the contention that genuinely held concerns should not be expressed or, if expressed, should attract censure.**

D. Consent and truth

1. It is self-evident that for it to have any meaning consent has to be informed. For the purposes of this document "informed consent" means that the practitioner involved explains the intended test or procedure to the patient without bias and in as much detail (including detail of possible reactions, complications, side effects and social or personal ramifications) as the patient requires. In the case of an unquestioning patient the practitioner assesses and determines what information the patient needs so that the patient may make an *informed* decision. The practitioner should impart the information in a sensitive manner, recognising that it might cause distress. The patient must be given time to consider the information before being required to give the consent unless it is an emergency situation.

2. In many instances the practitioner involved in obtaining informed consent would be a registered medical practitioner. In those circumstances it is the medical practitioner who should impart the information and subsequently seek the signed consent. Normally, in respect of patients in hospital, there are good reasons why the information should be given and the consent sought in the presence of a nurse, midwife or health visitor. Where the procedure or test is to be performed by a nurse, midwife or health visitor the standards described in the preceding paragraph apply to the consent sought.

3. If the nurse, midwife or health visitor does not feel that sufficient information has been given in terms readily understandable to the patient so as to enable him to make a truly informed decision, it is for her to state this opinion and seek to have the situation remedied. The practitioner might decide not to co-operate with a procedure if convinced that the decision to agree to it being performed was not truly informed. Discussion of such matters between the health professionals concerned should not take place in the presence of patients.

In certain situations and with certain client groups the practitioner's level of responsibility in this respect is greatly increased where she stands in "loco parentis" for a patient or client.

4. There are occasions on which, although the patient has been given information by the medical practitioner about an intended procedure for which he has given consent, his subsequent statements and questions to a nurse, midwife or health visitor indicate a failure to understand what is to be done, its risks and its ramifications. Where this proves to be the case it is necessary for that practitioner, in the patient's interest, to recall the relevant medical practitioner so that the deficiences can be remedied without delay.

The purpose of this approach is to ensure that all professional practitioners involved in the patient's care respect the primacy of that patient's interests, honour their personal professional accountability and avoid the risk of complaint or charges of assault. The practitioner who properly fulfils her responsibilities in this respect should be recognised by medical colleagues as a source of support and information to improve the overall care of the patient.

5. The concept of informed consent and that of truth telling are closely related. If it is to be believed that, on occasions, practitioners withhold information from their patients the damage to public trust and confidence in the profession, on which the introduction to the Code of Professional Conduct places great emphasis, will be enormous.

6. This is yet another area in which judgements have to be made and introduces another facet of the exercise of accountability. If it is accepted that the patient has a right to information about his condition it follows that the professional practitioners involved in his care have a duty to provide such information. Recognition of the patient's condition and the likely effect of the information might lead the professionals to be selective about 'what' and 'when' but the responsibility is on them to provide information. There may be occasions on which, after consultation with the relatives of a patient by the health professionals involved in that patient's care, some information is temporarily withheld. If, however, something less than the whole truth is told at a particular point in time it should never be because the practitioner is unable to cope with the effects of telling the whole truth. Such controlled release of information (i.e. less than the whole truth) should only ever be in the interests of the patient, and the practitioner should be able to justify the action taken.

7. It is recognised that this is an area in which there is the potential for conflict between professionals involved in the care of the same patient or client. The existence of good, trusting relationships between professionals concerned will promote the development of agreed approaches to truth telling. This subject should be discussed between all the professional practitioners involved so that the rights of patients are not affected adversely. This should minimise the number of occasions on which, after a patient or client has been given incomplete information, a nurse, midwife or health visitor is faced with a request for the whole truth. Accountability can never be exercised by ignoring the rights and interests of the patient or client.

E. Advocacy on behalf of patients and clients

1. The introductory paragraphs of the Code of Professional Conduct, together with several of its clauses, indicate clearly the expectation that the practitioner will accept a role as an advocate on behalf of his or her patients/clients. Opinions vary as to what exactly that means. Some tend to want to identify advocacy as a separate and distinct subject. It is not. It is a component of many professional activities of this and other professions. Some of these professional activities are the subject of other sections of this document.

2. **Advocacy is concerned with promoting and safeguarding the wellbeing and interests of patients and clients. It is not concerned with conflict for its own sake.** It is important that this fact is recognised, since some practitioners seem to regard advocacy on behalf of patients or clients as an adversarial activity and feel either attracted to it or not able to accept it for that reason. Dictionaries define an advocate as 'one who pleads the cause of another' or 'one who recommends or urges something' and indicates that advocacy is a positive, constructive activity.

3. There are occasions on which the practitioner's advocacy role has to be exercised to 'plead the cause of another' where, in the case of any person incapable of making informed decisions, the parents or relatives withhold consent for treatment which the various practitioners involved believe to be in the best interests of the patient. The parents or relatives, from their knowledge of the patient, will also have an opinion as to what constitutes his or her best interests. There have been a limited number of cases in which the courts have taken the view that the parents or relatives have not decided in the patient's best interests. Taking the right of decision away from the parents or relatives should only occur in the rarest of cases. The practitioner's advocacy role in situations of this kind requires knowledge of the patient's condition and prognosis, sensitivity to the feelings of the parents or relatives and considerable empathy.

4. **To fulfil the Council's expectations set out in the Code is, therefore, to be the advocate for the patient or client in this sense. Each practitioner must determine exactly how this aspect of personal professional accountability is satisfied within her particular sphere of practice. This requires the exercise of judgement as to the 'when' and 'how'. The practitioner must be sure that it is the interests of the patient or client that are being promoted rather than the patient or client being used as a vehicle for the promotion of personal or sectional professional interests. The Code of**

Professional Conduct envisages the role of patient or client advocate as an integral and essential aspect of good professional practice.

5. Just as the practice of nursing involves the practitioner in assisting the patient with those physical activities which he would do for himself were he able, so too the exercise of professional accountability involves the practitioner in assisting the patient by making such representations on his behalf as he would make himself if he were able.

F. Collaboration and co-operation in care

1. Clause 5 of the Code of Professional Conduct requires that '**Each registered nurse, midwife and health visitor, in the exercise of professional accountability shall work in a collaborative and co-operative manner with other health care professionals and recognise and respect their particular contributions within the health care team**'. This clause deliberately emphasises the importance of collaboration and co-operation and, by implication, the importance of the avoidance of dispute and the promotion of good relationships and a spirit of co-operation and mutual respect within the team.

2. It does so because it is clearly impossible for any one profession or agency to possess all the knowledge, skill and resources to be employed in meeting the total health care needs of society. The delivery of full and appropriate care to patients/clients frequently necessitates the participation of professional practitioners from more than one profession, their efforts often being supplemented by other agencies and persons.

The UKCC recognises the complexity of medical and health care and stresses the need to appreciate the complementary contribution of the professions and others involved.

The delivery of care is therefore often a multi-profession and multi-agency activity which, in order to be effective, must be based on mutual understanding, trust, respect and co-operation.

3. It is self-evident that collaborative and co-operative working is essential if patients and clients are to be provided with the care they need and if it is to be of the quality required. It is worthy of note that this concept of teamwork is evident in many situations in which the care of patients and clients is a shared responsibility. Unfortunately there are exceptions. Experience has demonstrated that such co-operation and collaboration is not always easily achieved if:–

(a) individual members of the team have their own specific and separate objectives;
or
(b) one member of the team seeks to adopt a dominant role to the exclusion of the opinions, knowledge and skill of its other members.

In such circumstances it is important to stress that the interests of the patient or client must remain paramount.

4. The UKCC and the General Medical Council agree that there is a range of issues which calls for co-operation

between the professions at both national and local level and wish to encourage this co-operation.

5. In spite of acceptance of the importance of co-operation and collaboration, differences can sometimes occur within the team regarding appropriate care and treatment. Such conflict can become an influence for good if it results in full discussion between members of the team. It may prove harmful to the care and treatment of patients or clients unless resolved in a manner which recognises the special contribution of each professional group, agency and individual and ensures that the interests and needs of the patient or client remain paramount.

6. **Collaboration and co-operation between health care professionals is also necessary in both research and planning related to the provision or improvement of services.** This may sometimes give rise to concern where one professional group is requested to pass information (obtained by its members in the course of professional practice) to a member of another professional group to use for a purpose other than that for which it was obtained and recorded. That level of concern will inevitably rise unless it can be seen that the purpose for which the information is required is valid, the information is made available only to persons bound by the same standards of confidentiality and the means of storage of that information is secure.

This should not present a problem where consent can be obtained from the patients or clients to whom the information relates or from relatives who have been provided with the relevant information. In certain fields, such as care of the elderly and persons with mental illness and mental handicap, the information gathering and research geared to the provision of services for these client groups may need to proceed without specific consent. This should only occur where the individuals receiving care are unable to give informed consent and where there is no close contact with relatives. Those who proceed without consent in these particular circumstances must be satisfied that their activities will not affect the current provision of care adversely and that the activity is directed to the provision of appropriate or improved services for future recipients of care.

It is anticipated that disputes will be avoided by relevant inter-professional discussions in advance of submissions of the projects for approval by the appropriate ethical committees. Where a dispute does arise it should be resolved between colleagues and the ethical committee.

Clause 9 of the Code of Professional Conduct and the UKCC's Advisory Paper on 'Confidentiality' provide further sources of reference for nurses, midwives and health visitors in respect of this aspect of practice.

G. Objection to participation in care and treatment

1. **Clause 7 of the Code of Professional Conduct states:**

> **'Make known to an appropriate person or authority any conscientious objection which may be relevant to professional practice.'**

2. The law does not provide a general opportunity for practitioners to register a conscientious objection to participation in care and treatment. That right applies in respect of termination of pregnancy only (not the care of the patient thereafter) under the terms of Section 4 of the Abortion Act 1967.

3. Some practitioners choose not to participate in certain other forms of treatment on the grounds of conscience. Since the law provides no basic right to such a refusal it is imperative that any practitioner should be careful not to accept employment in a post where it is known that a form of treatment to which she has a conscientious objection is regularly used. In circumstances where a practitioner finds that a form of treatment to which she objects, but which is not usually employed, is to be used she must declare that objection with sufficient time for her managers to make alternative staffing arrangements and must not refuse to participate in emergency treatment.

Some practitioners may object to participation in certain forms of treatment, such as resuscitative treatment of the elderly, the transfusion of blood, or electro-convulsive therapy. These practitioners must respect clause 7 of the Code and make their position clear to their professional colleagues and managers, and recognise that this may have implications for their contract of employment.

4. Objection to participation in treatment does not only occur as a product of conscience. It is the Council's stated position that, on each and every occasion a prescribed medication is being administered, the practitioner should ensure that, in her view, the patient is not presenting symptoms that contra-indicate its administration. The practitioner who is concerned about the administration of a particular drug in these circumstances might reasonably ask the prescribing doctor to attend the patient and, if the prescriber still requires it to be given, to request her to administer the medication if not fully reassured. The practitioner involved in such an incident should make a detailed record of the reasons why she felt concern and, if so, why she declined to administer prescribed medication.

5. The principle that applies in the previous paragraph can also be applied in appropriate circumstances to substances that are prescribed for topical use including wound dressings. Where the practitioner attending the

patient believes (from knowledge, published research evidence or from previous experience) that the prescribed substance may be harmful, or even more so where it is evident that it is actively harmful, she should make a record of the condition of the wound or site (where appropriate including a photographic record) and ask the prescribing medical practitioner to attend.

If the prescription stands after medical examination the practitioner, having chosen either to respond to the prescription or not, should make a detailed record of the reasons for her expressed concern and subsequent actions.

It is believed that the spirit of co-operation and mutual respect referred to at paragraph F1. of this document should make such situations exceptional.

6. Objections to participation in treatment are not always associated with the nature or form of treatment or its appropriateness in a particular set of circumstances. Some practitioners indicate their wish or active intention to refuse to participate in the delivery of care to patients with certain conditions. Such refusal may be associated particularly with patients suffering from Hepatitis B Infection and those with Acquired Immune Deficiency Syndrome, AIDS Related Complex or who are HIV sero-positive but asymptomatic.

Those who seek the UKCC's support for such actual or intended refusal are informed that the Code of Professional Conduct does not provide a formula for being selective about the categories of patient or client for whom the practitioner will care. To seek to be so selective is to demonstrate unacceptable conduct. The UKCC expects its practitioners to adopt a non-judgemental approach in the exercise of their caring role.

H. Summary of the principles against which to exercise accountability

1. **The interests of the patient or client are paramount.**

2. **Professional accountability must be exercised in such a manner as to ensure that the primacy of the interests of patients or clients is respected and must not be overridden by those of the professions or their practitioners.**

3. **The exercise of accountability requires the practitioner to seek to achieve and maintain high standards.**

4. **Advocacy on behalf of patients or clients is an essential feature of the exercise of accountability by a professional practitioner.**

5. **The role of other persons in the delivery of health care to patients or clients must be recognised and respected, provided that the first principle above is honoured.**

6. **Public trust and confidence in the profession is dependent on its practitioners being seen to exercise their accountability responsibly.**

7. **Each registered nurse, midwife or health visitor must be able to justify any action or decision not to act taken in the course of her professional practice.**

'Exercising Accountability' is the fourth in a series to supplement the Code of Professional Conduct (Second Edition; November 1984) and is made available free to all persons on the UKCC's professional register to assist them and to stimulate discussion of this important subject.

It should be read in conjunction with the Code of Professional Conduct for the Nurse, Midwife and Health Visitor and other UKCC Advisory Papers.

The Council, through its professional staff, is always willing to respond to individual requests for advice on matters related to professional practice.

Previous UKCC Advisory Documents in this series are:
(a) 'Advertising by Registered Nurses, Midwives and Health Visitors' (1985)
(b) 'Administration of Medicines' (1986)
(c) 'Confidentiality' (1987)

United Kingdom Central Council for Nursing, Midwifery and Health Visiting
23 Portland Place
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Tel: 0171-637 7181

March 1989

Code of Professional Conduct

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

June 1992

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

Third Edition
June 1992

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

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

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

1. act always in such a manner as to promote and safeguard the interests and well-being of patients and clients;
2. ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients;
3. maintain and improve your professional knowledge and competence;
4. acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner;
5. work in an open and co-operative manner with patients, clients and their families, foster their independence and recognise and respect their involvement in the planning and delivery of care;
6. work in a collaborative and co-operative manner with health care professionals and others involved in providing care, and recognise and respect their particular contributions within the care team;

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

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

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

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

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

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

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

14 assist professional colleagues, in the context of your own knowledge, experience and sphere of responsibility, to develop their professional competence

and assist others in the care team, including informal carers, to contribute safely and to a degree appropriate to their roles;

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

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

Notice to all Registered Nurses, Midwives and Health Visitors

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

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

Chief Executive/Registrar
United Kingdom Central Council
for Nursing, Midwifery and Health Visiting
23 Portland Place
London
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The Scope of Professional Practice

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

June 1992

The Scope of Professional Practice

A UKCC Position Statement

Introduction

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

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

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Education for Professional Practice

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

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

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

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

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

The Code of Professional Conduct and the Scope of Professional Practice

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

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

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

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

Principles for adjusting the Scope of Practice

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

9 The registered nurse, midwife or health visitor:

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

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

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

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

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

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

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

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

and residential care sector and support for professional practice.

The Scope and 'Extended Practice' of Nursing

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

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

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

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

The Scope of Midwifery Practice

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

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

The Scope of Health Visiting Practice

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

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

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

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

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

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

Practice in the Personal Social Services and Residential Care Sector

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

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

Support for Professional Practice

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

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

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

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

Guidelines for the administration of medicines

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

Protecting the public through professional standards

Guidelines for the administration of medicines

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

Protecting the public through professional standards

Guidelines for the administration of medicines

As the regulatory body for nursing, midwifery and health visiting, the primary function of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) is public protection through professional standards. One of the most important ways of serving the public interest is through providing advice and guidance to registrants on professional issues. The purpose of this booklet is to establish principles for safe practice in the management and administration of medicines by registered nurses, midwives and health visitors.

As many changes have taken place in relation to medicines management and the way health care is developed in the United Kingdom, it has been necessary to review the advice previously given by the UKCC on the administration of medicines. This booklet therefore replaces the 1992 document *Standards for the administration of medicines*. However, many of the principles contained in that guidance are of equal relevance today. For example:

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

Many government and other agencies are involved in medicines management, from manufacture, licensing, prescribing and dispensing, to administration. An extensive range of guidance on these issues is provided by the relevant bodies. Sources of information are listed on pages 13-14. One of the best sources of advice locally is usually your pharmacist.

As with all UKCC publications, this booklet is not intended to be a rule book or a manual. Nor is it intended to cover every single situation which a registered practitioner may encounter during a career. Instead, it sets out a series of guidelines or principles which we hope will enable practitioners to think through the issues and to apply their professional expertise and judgement in the best interests of

their patients. It will also be necessary to develop and refer to additional local policies or protocols to suit local needs. Within the document, the word 'patient' is used for convenience to refer to a person receiving medication, irrespective of the environment in which they are residing.

Principles in relation to the prescription

As a registered nurse, midwife or health visitor, you are accountable for your actions and omissions. In administering any medication, or assisting or overseeing any self-administration of medication, you must exercise your professional judgement and apply your knowledge and skill in the given situation.

When administering a medication against a prescription written manually or electronically by a registered medical practitioner or another authorised prescriber, the prescription should:

- be based, whenever possible, on the patient's informed consent and awareness of the purpose of the treatment
- be clearly written, typed or computer-generated and be indelible (please refer to the UKCC's *Guidelines for records and record keeping*)
- clearly identify the patient for whom the medication is intended
- record the weight of the patient on the prescription sheet where the dosage of medication is related to weight
- clearly specify the substance to be administered, using its generic or brand name where appropriate and its stated form, together with the strength, dosage, timing, frequency of administration, start and finish dates and route of administration
- be signed and dated by the authorised prescriber
- not be for a substance to which the patient is known to be allergic or otherwise unable to tolerate
- in the case of controlled drugs, specify the dosage and the number of dosage units or total course; if in an out-patient or community setting, the prescription should be in the prescriber's own handwriting; some prescribers are subject to handwriting exemption but the prescription must still be signed and dated by the prescriber.

Instruction by telephone to a practitioner to administer a previously unprescribed substance is not acceptable. In exceptional circumstances, where the medication has been previously prescribed and the prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary, the use of information technology (such as fax or e-mail) is the preferred method. This should be followed up by a new prescription confirming the changes within a given time period. The UKCC suggests a maximum of 24 hours. In any event, the changes must have been authorised before the new dosage is administered.

Prescribing

Detailed guidance on prescribing is contained in the *British National Formulary* (BNF) and in *Medicines, Ethics and Practice: A Guide for Pharmacists* (see page 15). Until 1992, prescribing was essentially restricted to doctors and dentists.

Prescribing by nurses and health visitors

The *Medicinal Products: Prescription by Nurses Act 1992* and subsequent amendments to the Pharmaceutical Services regulations allow registered health visitors and district nurses, who have recorded their qualification on the UKCC register, to become nurse prescribers. The preparation for this new area of practice is also included in the appropriate programmes to enable newly-qualified district nurses and health visitors to prescribe.

Practitioners whose prescribing status is denoted on the register, and who are approved within their employment setting, may prescribe from the *Nurse Prescribers' Formulary*. Nurse prescribers must comply with the current legislation for prescribing and be accountable for that practice.

Patient group directions (group protocols)

Changes to medicines legislation, which came into effect in August 2000, clarify the law in relation to the supply or administration of medicines under patient group directions, previously described as group protocols. You must follow the guidance supplied by your government health department regarding implementation.

A patient group direction is a specific written instruction for the supply and administration of a named medicine or vaccine in an identified clinical situation. It applies to groups of patients who may not be individually identified before presenting for treatment. Patient group directions are drawn up locally by senior doctors, or if appropriate dentists, pharmacists and other health professionals. They must be signed by a doctor or dentist and a senior pharmacist, both of whom

should have been involved in developing the direction, and approved by the appropriate health care body.

Dispensing

If, under exceptional circumstances, you are required to dispense, there is no legal barrier to this practice. However, this must be in the course of the business of a hospital and in accordance with a doctor's written instructions.

In a dispensing doctor's practice, nurses may supply to patients under a particular doctor's care, when acting under the directions of a doctor from that practice.

Dispensing includes such activities as checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product, labelling in accordance with legal requirements and providing information leaflets for the patient.

If you, as a registered nurse, midwife or health visitor, are engaged in dispensing, this represents an extension to your professional practice and you must adhere to the principles set out in the UKCC's *The scope of professional practice*. The patient has the legal right to expect that the dispensing will be carried out with the same reasonable skill and care which would be expected from a pharmacist.

Principles for the administration of medicines

In exercising your professional accountability in the best interests of your patients, you must:

- know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications
- be certain of the identity of the patient to whom the medicine is to be administered
- be aware of the patient's care plan
- check that the prescription, or the label on a medicine dispensed by a pharmacist, is clearly written and unambiguous
- have considered the dosage, method of administration, route and timing of the administration in the context of the condition of the patient and co-existing therapies
- check the expiry date of the medication to be administered

- check that the patient is not allergic to the medication before administering it
- contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medication are discovered, where the patient develops a reaction to the medication, or where assessment of the patient indicates that the medication is no longer suitable
- make a clear, accurate and immediate record of all medication administered, intentionally withheld or refused by the patient, ensuring that any written entries and the signature are clear and legible; it is also your responsibility to ensure that a record is made when delegating the task of administering medication
- where supervising a student nurse or midwife in the administration of medicines, clearly countersign the signature of the student.

Some drug administrations can require complex calculations to ensure that the correct volume or quantity of medication is administered. In these situations, it may be necessary for a second practitioner to check the calculation in order to minimise the risk of error. The use of calculators to determine the volume or quantity of medication should not act as a substitute for arithmetical knowledge and skill.

It is unacceptable to prepare substances for injection in advance of their immediate use or to administer medication drawn into a syringe or container by another practitioner when not in their presence. An exception to this is an already established infusion which has been instigated by another practitioner following the principles set out above, or medication prepared under the direction of a pharmacist from a central intravenous additive service and clearly labelled for that patient.

In an emergency, where you may be required to prepare substances for injection by a doctor, you should ensure that the person administering the drug has undertaken the appropriate checks as indicated above.

Midwives should refer to the UKCC's *Midwives rules and code of practice* for specific additional information.

Aids to support concordance (compliance aids)

Self-administration from dispensed containers may not always be possible for some patients. If an aid to concordance is considered necessary, careful attention should

be given to the assessment of the patient's suitability and understanding of how to use an appropriate aid safely. However, all patients will need to be regularly assessed for continued appropriateness of the aid. Ideally, any concordance aid, such as a monitored dose container or a daily/weekly dosing aid, should be dispensed, labelled and sealed by a pharmacist.

Where it is not possible to get a concordance aid filled by a pharmacist, you should ensure that you are able to account for its use. The patient has a right to expect that the same standard of skill and care will be applied by you in dispensing into a concordance aid as would be applied if the patient was receiving the medication from a pharmacist. This includes the same standard of labelling and record keeping. Compliance aids, which are able to be purchased by patients for their own use, are aids which are filled from containers of dispensed medicines. If you choose to repackage dispensed medicines into compliance aids, you should be aware that their use carries a risk of error.

Self-administration of medicines

The UKCC welcomes and supports the self-administration of medicines and the administration of medication by carers wherever it is appropriate. However, the necessary safety, security and storage arrangements must be available and, where necessary, agreed procedures must be in place.

For the hospital patient approaching discharge, but who will continue on a prescribed medicines regime on the return home, there are obvious benefits in adjusting to the responsibility of self-administration while still having access to professional support. It is essential, however, that where self-administration is introduced, arrangements are in place for the safe and secure storage of the medication, access to which is limited to the specific patient.

Where self-administration is taking place, you should ensure that records are maintained appropriate to the environment in which the patient is being cared for.

It is also important that, if you are delegating this responsibility, you ensure that the patient or carer/care assistant is competent to carry out the task (please refer to the UKCC's *Guidelines for professional practice)*. This will require education, training and assessment of the patient or carer/care assistant and further support if necessary. The competence of the person to whom the task has been delegated should be reviewed periodically.

Complementary and alternative therapies

Complementary and alternative therapies are increasingly used in the treatment of patients. Registered nurses, midwives and health visitors who practise the use of such therapies must have successfully undertaken training and be competent in this area (please refer to *The scope of professional practice*). You must have considered the appropriateness of the therapy to both the condition of the patient and any co-existing treatments. It is essential that the patient is aware of the therapy and gives informed consent.

Management of errors or incidents in the administration of medicines

It is important that an open culture exists in order to encourage the immediate reporting of errors or incidents in the administration of medicines. If you make an error, you must report it immediately to your line manager or employer.

Registered nurses, midwives and health visitors who have made an error, and who have been honest and open about it to their senior staff, appear sometimes to have been made the subject of local disciplinary action in a way which might discourage the reporting of incidents and, therefore, be potentially detrimental to patients and the maintenance of standards.

The UKCC believes that all errors and incidents require a thorough and careful investigation at a local level, taking full account of the context and circumstances and the position of the practitioner involved. Such incidents require sensitive management and a comprehensive assessment of all the circumstances before a professional and managerial decision is reached on the appropriate way to proceed. If a practising midwife makes or identifies a drug error or incident, she should also inform her supervisor of midwives as soon as possible after the event.

The UKCC supports the use of local multi-disciplinary critical incident panels, where improvements to local practice in the administration of medicines can be discussed, identified and disseminated.

When considering allegations of misconduct arising from errors in the administration of medicines, the UKCC's Professional Conduct Committee takes great care to distinguish between those cases where the error was the result of reckless or incompetent practice or was concealed, and those which resulted from other causes, such as serious pressure of work, and where there was immediate, honest disclosure in the patient's interest. The UKCC recognises the prerogative of

managers to take local disciplinary action where it is considered to be necessary but urges that they also consider each incident in its particular context and similarly discriminate between the two categories described above.

Legislation

There are a number of pieces of legislation which relate to the prescribing, supply, storage and administration of medicines. It is essential that you comply with them. The following is a summary of those which are of particular relevance.

Medicines Act 1968

This was the first comprehensive legislation on medicines in the United Kingdom. The combination of this primary legislation and the various statutory instruments (secondary legislation) on medicines produced since 1968 provides the legal framework for the manufacture, licensing, prescription, supply and administration of medicines.

Among recent statutory instruments of particular relevance to registered nurses, midwives and health visitors is *The Prescription Only Medicines (Human Use) Order 1997, SI No 1830*. This consolidates all previous secondary legislation on prescription-only medicines and lists all of the medicines in this category. It also sets out who may prescribe them. The sections on exemptions are of particular relevance to midwives, including those in independent practice, and to nurses working in occupational health settings.

The *Medicines Act 1968* classifies medicines into the following categories:

- **Prescription-only medicines (POMs)**
  These are medicines which may only be supplied or administered to a patient on the instruction of an appropriate practitioner (a doctor or dentist) and from an approved list for a nurse prescriber. The pharmacist is the expert on all aspects of medicines legislation and should be consulted.
- **Pharmacy-only medicines**
  These can be purchased from a registered primary care pharmacy, provided that the sale is supervised by the pharmacist.
- **General sale list medicines (GSLs)**
  These need neither a prescription nor the supervision of a pharmacist and can be obtained from retail outlets. Generally, no medication should be

administered without a prescription. However, local policies or patient group directions should be developed to allow the limited administration of medicines in this group to meet the needs of patients.

Misuse of Drugs Act 1971

This prohibits the possession, supply and manufacture of medicinal and other products except where such possession, supply and manufacture has been made legal by the *Misuse of Drugs Regulations 1985*. The legislation is concerned with controlled drugs and categorises these into five separate schedules. As a registered nurse, midwife or health visitor, you should be particularly familiar with the regulations concerning schedule 2 medicines such as morphine, diamorphine and pethidine, and schedule 3 drugs such as barbiturates.

If you are responsible for the storage or administration of controlled drugs, you should be aware of the content of the *Misuse of Drugs Regulations 1985* and the *Misuse of Drugs (Safe Custody) Regulations 1973*. Queries are often raised in relation to prescriptions for schedule 2 medicines (controlled drugs). The legislation states that the prescription should:

- be in ink or such as to be indelible, and be signed and dated by the prescriber, issuing it in their usual handwriting with their signature
- specify the dose to be taken and, in the case of a prescription containing a controlled drug which is a preparation, the form and, where appropriate, the strength of the preparation, and either the total quantity (in both words and figures) of the preparation or the number (in both words and figures) of dosage units, as appropriate, to be supplied; in any other case, the total quantity (in both words and figures) of the controlled drug to be supplied.

If you have any queries in relation to the misuse of drugs, or if you are aware of illicit substances being in the possession of a patient, you must refer to and act on local policy and/or appropriate government health department guidance.

Unlicensed medicines

An unlicensed medicine is the term used to refer to a medicine which has no product licence. If an unlicensed medicine is administered to a patient, the manufacturer has no liability for any harm which ensues. The person who prescribes the medicine carries the liability. This may have implications for you in obtaining informed consent.

If a medicine is unlicensed, it should only be administered to a patient against a patient-specific prescription and not against a patient group direction. However, medication which is licensed but used outside its licensed indications may be administered under a patient group direction if such use is exceptional, justified by best practice and the status of the product is clearly described. In addition, you should be satisfied that you have sufficient information to administer the drug safely and, wherever possible, that there is acceptable evidence for the use of that product for the intended indication.

October 2000

Sources of information and advice

This is not intended to be a definitive list but simply a guide to some of the organisations which can provide you with additional information and advice in relation to the administration of medicines.

Royal Pharmaceutical Society of Great Britain
1 Lambeth High Street
London SE1 7JN

Telephone 020 7735 9141

The Pharmaceutical Society of Northern Ireland
73 University Street
Belfast BT7 1HL

Telephone 028 90 326 927

Scottish Pharmaceutical General Council
42 Queen Street
Edinburgh EH2 3NH

Telephone 0131 467 7766

Office of the Chief Pharmacist
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

Telephone 020 7210 5761

Home Office
50 Queen Anne's Gate
London SW1H 9AP

Telephone 020 7273 3474

Medicines Control Agency
Market Towers
1 Nine Elms Lane
London SW8 5NQ

Telephone 020 7273 0000

Medical Devices Agency
Hannibal House
Elephant and Castle
London SE1 6TQ

Telephone 020 7972 8124

UKCC Professional Advice Service
23 Portland Place
London W1N 4JT

Telephone 020 7333 6541/6550/6553 fax 020 7333 6538
e-mail advice@ukcc.org.uk

Useful publications

The *British National Formulary* and the *Nurse Prescribers' Formulary* are published jointly by the British Medical Association and the Royal Pharmaceutical Society of Great Britain. Copies are available from the Pharmaceutical Press, PO Box 151, Wallingford, Oxfordshire OX10 8QU. The *Monthly Index of Medical Specialities* (MIMS) is available from MIMS Subscriptions, PO Box 43, Ruislip, Middlesex HA4 0YT, telephone 020 8845 8545 or fax 020 8845 7696.

The *Review of Prescribing, Supply and Administration of Medicines: A Report on the Supply and Administration of Medicines under Group Protocols*, (Crown I) (Department of Health, London, April 1998) was published under cover of Health Service Circular (HSC) 1998/051 in England; Management Executive letter (MEL) (98)29 in Scotland; Welsh Health Circular (WHC) (98)27 in Wales, and by each Chief Professional Officer to their respective professional groups in Northern Ireland. Copies are available from the NHS response line on 0541 555 455. The *Review of Prescribing, Supply and Administration of Medicines: Final Report* (Crown II) (Department of Health, London 1999) is available from the same source. *Medicines, Ethics and Practice: A Guide for Pharmacists* is published annually and is available from the Royal Pharmaceutical Society of Great Britain (see page 13 for contact details). Copies of all legislation cited in this publication are available from local branches of The Stationery Office (formerly HMSO). The drugs manufacturer's data sheet is also an essential source of information.

Selected UKCC publications at October 2000

**Code of professional conduct * ** June 1992

**The scope of professional practice * ** June 1992

Guidelines for professional practice * June 1996

Complaints about professional conduct March 1998

Guidelines for mental health and learning disabilities nursing April 1998

A UKCC guide for students of nursing and midwifery July 1998

Guidelines for records and record keeping ** October 1998

Midwives rules and code of practice ** December 1998

A guide to the UKCC's professional advice service February 1999

Practitioner-client relationships and the prevention of abuse September 1999

Nursing in secure environments November 1999

The scope of professional practice – a study of its implementation January 2000

The nursing, midwifery and health visiting contribution to the continuing care of people with mental health problems April 2000

Guidelines for the administration of medicines** October 2000

* currently under review

** also available in Welsh

To obtain copies of any of these publications, please write to the UKCC Distribution Department at 23 Portland Place, London, W1N 4JT, by e-mail at publications@ukcc.org.uk or by fax on 020 7436 2924. All UKCC publications are available free of charge and most are available in unlimited quantities.

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Protecting the public through professional standards

Guidelines for professional practice

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for Nursing, Midwifery and Health Visiting

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for Nursing, Midwifery and Health Visiting

Contents

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.

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

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.

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.

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.

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."

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.

What is reasonable?

15 The courts and the Professional Conduct Committee must decide whether your actions were reasonable. The case 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.

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

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.

Communicating

22 Communication is an essential part of good practice. The patient or client can only make an informed choice if he or she is given clear information at every stage of care. You also need to listen to the patient or client. Listening is a vital part of communication. Effective communication relies on all our skills. Building a trusting relationship will greatly improve care and help to reduce anxiety and stress for patients and clients, their families and their carers. For effective communication, you may need to consult other colleagues with specialist knowledge, or you may need the services of interpreters to make sure that information is understood. It is important to create an environment for good communication so that you can build a relationship of trust with the patient or client. Employers should recognise the importance of communication when they plan staffing structures and levels.

23 To ensure that you gain the trust of your patients and clients, you should recognise them as equal partners, use language that is familiar to them and make sure that they understand the information you are giving. Your records must also be clear, legible and accessible to the patient or client, as outlined in the UKCC's document Standards for Records and Record Keeping and under the terms of the Data Protection Act 1984 and the Access to Health Records Act 1990. Written communication is as important as verbal communication.

Truthfulness

24 Patients and clients have a legal right to information about their condition; registered practitioners providing care have a professional duty to provide such information. A patient or client who wants information is entitled to an honest answer. There may be rare occasions when a person's condition and the likely effect of information given at a specific time might lead you to be selective (although never untruthful) about the information you give. Any

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.

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.

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.

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.

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.

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

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.

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

- 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.

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;"

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.

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.

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

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

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.

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

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.

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.

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?

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.

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.

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

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.

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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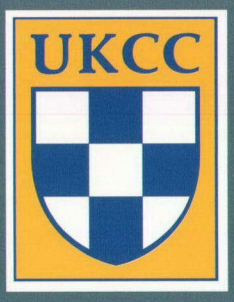

Reporting unfitness to practise – information for employers and managers

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

Reporting unfitness to practise – information for employers and managers

Introduction

This booklet should help you if you are trying to decide whether or not to report an unfit practitioner to the UKCC. It describes the type of unfitness you ought to report and tells you about the information you should send to us when reporting a case.

You can find more detailed information about our procedures for dealing with unfitness to practise in our booklet *Complaints about professional conduct*. Please call us on 0171 333 6564 or 0171 333 6572 if you don't already have a copy.

Who or what to report

The UKCC deals only with practitioners whose condition is serious enough to justify removing or suspending their registration. This means that the condition must seriously impair the practitioner's fitness to practise.

The purpose of removal or suspension is to protect the public. If practitioners voluntarily stop working when they are unable to practise safely, they are not a risk to the public. There is no need to report these people to the UKCC.

On the other hand, some practitioners continue working even when they are unable to practise safely. They put the public at risk because they do not understand that their condition makes them unfit to practise. These are the practitioners you should report to the UKCC. Examples of conditions that might seriously impair a practitioner's fitness to practise include:

- alcohol dependency
- drug dependency
- untreated serious mental illness
- serious personality disorder.

Demonstrating unfitness to practise

The UKCC's Health Committee must be satisfied that a practitioner is unfit. If the committee agrees that the practitioner's fitness to practise is seriously impaired, it will remove or suspend their registration. You must support your case with as much information as possible. The UKCC can ask practitioners for medical reports, but the practitioners may refuse to release this information. If this happens, your report could be the only information the committee has about the practitioner.

The committee must have good grounds for deciding that a practitioner's fitness to practise is seriously impaired. If your report does not show clearly enough that the practitioner is unfit, the case is unlikely even to get to the committee.

Reporting a case to the UKCC

Your report to the UKCC must be made in the form of a statutory declaration. All you have to do is send us your information about the practitioner's health problem. Please address your letter to the manager of the Professional Conduct Department. We will pass your report to the UKCC's solicitors and they will prepare the statutory declaration for you to sign.

We will send a copy of the statutory declaration to the practitioner. If the case comes before the Health Committee, the practitioner can require you to attend. If you include in your statutory declaration information from someone else, the practitioner can also require that person to attend. However, this happens very rarely.

Make sure you let us have as much information as possible so that the Health Committee can get the full picture. You are allowed to include in your statutory declaration information that other people have told you. To assess the case properly, we need:

- the practitioner's full name, PIN and most recent address
- details of the practitioner's sickness record and copies of any medical reports
- an account of any behaviour or incidents which show unfitness to practise
- copies of witness statements about any such behaviour or incidents
- copies of management notes of any hearings where the practitioner's fitness to practise has been discussed.

Interim suspension of registration

In exceptional cases, the UKCC can suspend a practitioner's registration **before** the case comes to the Health Committee. This is called interim suspension.

Interim suspension is generally carried out by the Preliminary Proceedings Committee. Obviously, it is a very serious step. The information has not been tested and the practitioner's fitness to practise has not been found to be seriously impaired. The committee cannot suspend a practitioner's registration unless it has evidence of continuing serious risk to either patients or practitioner.

If you think a case may justify interim suspension, please get in touch with us immediately. Even though you may not have much information, give us as much as you can. If you have involved the police, let us have the details of the police officer in charge of the case.

Advice

If you have any questions, or if you would like to discuss a particular case, you can call the UKCC's Professional Conduct Department on 0171 333 6564 or 0171 333 6572.

August 1996

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Reporting misconduct – information for employers and managers

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

Reporting misconduct – information for employers and managers

Introduction

This booklet should help you if you are trying to decide whether or not to report misconduct to the UKCC. It describes the type of misconduct you ought to report and tells you about the evidence we need to prove a case.

You can find more detailed information about the UKCC's procedures for dealing with alleged misconduct in our booklet *Complaints about professional conduct*. Please call us on 0171 333 6564 or 0171 333 6572 if you don't already have a copy.

What to report

The UKCC deals only with misconduct which, if proved, would be serious enough to justify removing the practitioner's name from the register. The purpose of removal is to protect the public, not to punish the practitioner. Conduct which results in dismissal from work might not justify removal from the register. Please remember this when deciding whether to report a case to the UKCC.

There is no list of offences which automatically lead to removal. The types of misconduct which could have this result include:

- physically or verbally abusing patients
- stealing from patients
- failing to care for patients properly
- failing to keep proper records
- committing serious criminal offences.

Proving misconduct

Even if the allegations which you report are serious enough to justify removal, they must also be provable. Allegations of misconduct have to be proved to the UKCC's Professional Conduct Committee. The committee applies the criminal standard of proof to the evidence it receives. This means that the committee must be satisfied 'beyond reasonable doubt' that an allegation is proved. The situation is often different at disciplinary hearings, where allegations can be proved 'on the balance of probabilities'.

When reporting a case, please think about what evidence there is to prove the allegations. Your complaint is unlikely even to get to the Professional Conduct Committee if the evidence is not sufficient to prove the case beyond reasonable doubt.

Evidence

The Professional Conduct Committee considers cases of alleged misconduct at public hearings where it can fully examine the evidence. To ensure a fair hearing, the committee must apply rules to govern the evidence it receives. These rules are similar to those which the criminal courts apply.

Probably the most important rules you need to know about are those concerning witnesses. The people who directly saw and heard what happened must be willing to come to the hearing and give evidence. Often, this means asking care assistants and junior staff to give evidence. Sometimes, you will have to ask patients if they will be witnesses.

If exceptional circumstances prevent a witness from attending the hearing, the rules of evidence **may** allow the committee to receive their statement. However, this is rarely permitted and you must not suggest it to witnesses as an alternative means of giving evidence.

If witnesses feel worried about attending the hearing, you may tell them that a manager they know can come with them. If patients have to give evidence, they can come with a member of their family, a friend, or a nurse who is caring for them. You may also like to tell patients that they will not be identified by name at the hearing.

Before you report a case, make sure the witnesses are willing to come to the hearing to give evidence. If someone does not want to attend, or cannot, you must tell us straight away.

Reporting a case to the UKCC

If you think your complaint could be proved and is serious enough to justify removal, report it to us immediately. Please do not wait until after any appeal or tribunal. Put your report in writing and send it to the manager of the Professional Conduct Department. Set out all the facts as fully and clearly as possible. To assess the case properly, we need:

- the practitioner's full name, PIN and most recent address
- a description of the practitioner's job at the time of the alleged misconduct
- a description of the workplace, including the number and types of clients for whom the practitioner was responsible
- a description of staff numbers, grades and reporting lines at the workplace
- an account of the alleged incident
- copies of any witness statements
- copies of any relevant documents such as care plans, accident forms, drug administration records, financial records and work diaries
- copies of management notes of any investigative or disciplinary hearings
- details of any police involvement and the name and address of the officer in charge of the case
- details of the practitioner's previous jobs
- details of any relevant post-registration courses which the practitioner has attended
- details of any previous disciplinary action or counselling.

Interim suspension of registration

In exceptional cases, the UKCC can suspend a practitioner's registration **before** the case comes to the Professional Conduct Committee. This is called interim suspension.

Interim suspension is generally carried out by the Preliminary Proceedings Committee. Obviously, it is a very serious step. The evidence has not been tested and the practitioner has not been found guilty of misconduct. The committee cannot suspend a practitioner's registration unless it has evidence of continuing serious risk to either patients or practitioner. If you are dealing with a case like this, it is likely that you will have involved the police.

If you think a case may justify interim suspension, please get in touch with us immediately. Even though you may not have much information, tell us as much you can. If you have involved the police, let us have the details of the police officer in charge of the case.

Advice

If you have any questions, or if you would like to discuss a particular case, you can call the UKCC's Professional Conduct Department on 0171 333 6564 or 0171 333 6572

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