Overview of National Standards, Professional, Regulatory and Legislative Policy guiding Nursing and Midwifery Practice in Ireland

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Learning Outcomes

By the end of this session I will:

What do you want to know or do at the end of this session?
Nurses and Midwives Act 2011

“AN ACT FOR THE PURPOSE OF THE ENHANCEMENT OF THE PROTECTION OF THE PUBLIC IN ITS DEALINGS WITH NURSES AND MIDWIVES AND, FOR THAT PURPOSE, TO PROVIDE FOR A BOARD TO BE KNOWN AS BORD ALTRANAIS AGUS CNÁIMHSEACHAIS NA hÉIREANN, OR IN THE ENGLISH LANGUAGE, THE NURSING AND MIDWIFERY BOARD OF IRELAND, TO RECOGNISE MIDWIFERY AS A SEPARATE PROFESSION, TO PROVIDE FOR THE REGISTRATION, REGULATION AND CONTROL OF NURSES AND MIDWIVES, TO ENHANCE THE HIGH STANDARDS OF PROFESSIONAL EDUCATION, TRAINING AND COMPETENCE OF NURSES AND MIDWIVES, TO INVESTIGATE COMPLAINTS AGAINST NURSES AND MIDWIVES AND TO INCREASE THE PUBLIC ACCOUNTABILITY OF THE BOARD, TO DISSOLVE THE NATIONAL COUNCIL FOR THE PROFESSIONAL DEVELOPMENT OF NURSING AND MIDWIFERY, TO REPEAL THE NURSES ACT 1985 AND TO PROVIDE FOR RELATED MATTERS.

(21 December 2011)”

Acts referred to within Nurses and Midwives Act 2011

- Adoptive Leave Acts 1995 and 2005
- Carer’s Leave Act 2001
- Companies Act 1990
- Comptroller and Auditor General (Amendment) Act 1993
- Ethics in Public Office Act 1995
- Freedom of Information Act 1997
- Health Act 2004
- Health Act 2007
- Health and Social Care Professionals Act 2005
- Local Government (Superannuation) Act 1980
- Local Government Act 2001
- Maternity Protection Acts 1994 and 2004
- Medical Practitioners Act 2007
- Misuse of Drugs Acts 1977 and 1984
- Nurses Act 1985
- Organisation of Working Time Act 1997
- Parental Leave Acts 1998 and 2006
- Petty Sessions (Ireland) Act 1851
- Protection of Employees (Fixed-Term Work) Act 2003
- Protection of Employees (Part-Time Work) Act 2001
- Public Service Management (Recruitment and Appointments) Act 2004
- Public Service Superannuation (Miscellaneous Provisions) Act 2004
- Redundancy Payments Acts 1967 to 2007
- Standards in Public Office Act 2001
- Unfair Dismissals Acts 1977 to 2007
Nurses Rules

- Statutory Instrument 435 of 2013: Nurses and Midwives Rules 2013 (supplemental to Nurses Rules 2010).
Legislation

- Children’s Act 2001
- Data Protection Acts, 1988 and 2003
- Electronic Commerce Act, 2000
- Freedom of Information Act, 2014
- Health Act 2007 (Care and Welfare of Residents In Designated Centres for Older People) Regulations 2013
- Mental Health Act, 2001
- Non-Fatal Offences against the Person Act, 1997
- Statute of Limitations Act, 1957
- Statute of Limitations (Amendment) Act, 1991
Professional Regulation

Nursing and Midwifery Board of Ireland
National Regulation
Health Information and Quality Authority

20/09/2017

Documentation for PHN and Community RNs
Cork/Kerry
National Clinical Effective Committee National Clinical Guidelines
Department of Health Policy
National Health Service Executive Policies, Procedures, Protocols and Guidelines
Local Policies, Procedures, Protocols and Guidelines

20/09/2017 Documentation for PHN and Community RNs
Cork/Kerry
Nursing and Midwifery Values
HSE Values
Person Centred Practice Framework
Overload?

"How much time did you say I had to know these?"

Nurses are on the front lines, and a mistake can be the difference between life and death. The physical and emotional toll of this work can lead to a great deal of stress and eventual burnout.

The right policy management for nurses can ensure that policies and procedures that guide patient care are easily accessible and nurses are properly supported.
Documentation

Who?  What?
Where?  Why?
When?  How?
WHO?

The nurse or midwife involved in the assessment, planning, implementation, evaluation, communication and education should be the person who documents this.

“Nurses/midwives should not, as a general rule, record or document care on behalf of someone else.” (NMBI, 2015, p.15)
WHAT?

• At a minimum, a patient record should include the following;
  
  • i. An accurate assessment of the person’s physical, psychological and social wellbeing, and, whenever necessary, the views and observations of family* members in relation to that assessment,
  
  • ii. Evidence in relation to the planning and provision of nursing/midwifery care,
  
  • iii. An evaluation of the effectiveness, or otherwise, of the nursing/midwifery care provided.
  
• Narrative notes should be written frequently enough to give a picture of the patient’s/client’s condition and care to anyone reading them. They should provide a record against which improvement, maintenance or deterioration in the patient’s/client’s condition may be judged.

(NMBI, 2015, p.11)
WHERE?

“Nurses and midwives who transport records outside the healthcare organisation should take all reasonable steps to ensure the safety and security of such records. Records should be returned to their appropriate storage facility as soon as reasonably possible after use.”

(NMBI 2015, p.5)
WHEN?

“Documentation in the record is carried out as soon as possible after providing nursing/midwifery care.”

(NMBI, 2015 p.12)
WHY?

“The quality of records maintained by nurses and midwives is a reflection of the quality of the care provided by them to patients. Nurses and midwives are professionally and legally accountable and responsible for the standard of practice which they deliver and to which they contribute. Good practice in record management is an integral part of quality nursing and midwifery practice.” NMBI, 2015, p.3
HOW?

The Nursing Process (ADPIE): Planning and Implementation
- Use the acronym SMART to guide your Planning and Implementation:
  - Specific
  - Measurable
  - Achievable
  - Realistic
  - Time-specific
“Nurses must allocate time for both hands-on care and documentation, as it is the two together that constitute total patient care. If record-keeping is seen as a chore, there is a risk that the documentation will fall short of the standard expected of a professional.”

Wood, 2013
Evidence of Documentation

“There was noted improvement in the nursing documentation since the last inspection such as the updating of care plans post a change in the residents condition and the person centred content. However, there were still some gaps in the nursing records reviewed……………. A comprehensive and personalised assessment of each resident’s health and social care needs was undertaken on admission. A range of evidence based tools were used to assess and identify any changes in areas such as nutrition and hydration, dependency, skin integrity, oral care and risk of falls. All assessments were reviewed within a four month period. However, areas such as end of life were not always assessed in detail and where the resident had refused to discuss this topic this was not documented.”

(HIQA, 2016 p.5)

Findings and Decisions following Fitness to Practise Committee Inquiries

Name: Ms ABC* PIN: 123*
Finding of the Fitness to Practise Committee: Professional misconduct

That you, being a registered nurse:

When you were working as a Nurse at X Nursing Home, on 5th June 2011:

- Failed to provide any or adequate care to a resident, Ms Y
- Failed to make any or any adequate record of the incident involving Ms Y which took place at approximately 11am on 5th June 2011

Sanction: Pursuant to Section 41(1) of the Nurses Act, 1985, Ms ABC* was censured in relation to her professional conduct and pursuant to Section 40(1) of the Act, a Condition was attached to the retention of Ms ABC*’s name in the Register of Nurses and Midwives. The decision to attach a condition to the retention of Ms ABC*’s name in the Register of Nurses and Midwives was confirmed by the High Court on 19th January 2015.

* Name and NMBI PIN have been excluded to protect identity, however this was taken directly from NMBI Fitness to Practise Findings and Decisions which are publically accessible on the NMBI website
Findings and Decisions following Fitness to Practise Committee Inquiries

Name: Ms DEF* PIN: 345*
Finding of the Fitness to Practise Committee: Professional misconduct

Allegations proven: While employed as a staff nurse at Hospital X, you fell seriously short of the standard of nursing practice that could be expected in that:

• On or around 06 September 2010 and/or 07 September 2010 and/or 08 September 2010 you:
  o Failed to adhere to the correct procedure for the signing of medication for one or more of the following patients who were under your care: Ms A.
  o Failed to adequately record the clinical observations and/or the vital signs of one or more of the following patients who were under your care: Mr B and Ms A.

Arising from one or more of the Allegations above, the failure to comply on one or more occasions with the following:
  o An Bord Altranais "Guidance to Nurses and Midwives on Medication Management" (July 2007),
  o An Bord Altranais "Recording Clinical Practise - Guidance to Nurses and Midwives" (November 2002), and
  o Policies, Procedures, Protocols and Guidelines (PPPG) in place in the Hospital.

Sanction: Pursuant to Section 41(1) of the Nurses Act, 1985, Ms DEF* was censured in relation to her professional conduct.

* Name and NMBI PIN have been excluded to protect identity, however this was taken directly from NMBI Fitness to Practise Findings and Decisions which are publically accessible on the NMBI website
Findings and Decisions following Fitness to Practise Committee Inquiries (Nurses Act, 1985)

Name: Ms GHI*; PIN: 789*
Finding of the Fitness to Practise Committee: Professional misconduct

Allegations proven: That you, being a registered nurse, while employed at Nursing Home A ("the Nursing Home") as Person in Charge from on or around 12 March 2012 to on or around 27 April 2012:

• The failure to maintain any or any adequate nursing documentation to include one or more of the following:
  • Care plans;
  • Current and/or appropriate nursing records;
  • An audit of falls;
  • Falls assessments and/or reassessments;
  • Risk assessments;
  • Wound care folder;
  • Pain assessment records;
  • Assessments in relation to the use of restraints;
  • Audits of accidents and/or incidents;

• The failure to adopt and/or implement any, or any adequate, policies and/or procedures in respect of one or more of the following:
  • Medication Management Policy

• Sanction: Pursuant to Section 41(1) of the Nurses Act, 1985, Ms GHI* was censured in relation to her professional conduct and pursuant to Section 40(1) of the Act, a Condition was attached to the retention of Ms GHI’s* name in the Register of Nurses and Midwives. The decision to attach a condition to the retention of Ms GHI’s* name in the Register of Nurses and Midwives was confirmed by the High Court on 3rd April 2017.
Guidelines for Good Practice in Recording Clinical Practice (NMBI, 2015)

• The quality of a nurse’s/midwife’s record keeping should be such that continuity of care for a patient/family is always supported.

• All narrative notes are individualised, accurate, up to date, factual and unambiguous.

• All written records are legible.

• All entries are signed.

• All entries are dated.

• Entries in the record are in chronological order.
Guidelines for Good Practice in Recording Clinical Practice (NMBI, 2015)

• Documentation in the record is carried out as soon as possible after providing nursing/midwifery care.
• All entries are timed, especially where the condition of the patient is changing or liable to change frequently.
• Abbreviations should only be used if drawn from a list approved by the healthcare service.
• Accepted grading systems should only be used.
Guidelines for Good Practice in Recording Clinical Practice (NMBI, 2015)

• Entries made in error should be bracketed and have a single line drawn through them so that the original entry is still legible. Errors should be signed and dated.

• Nurse/midwife making the referral or consulting with another member of the healthcare team should clearly identify, by name, the person in the record.

• All decisions to take no immediate action but review the situation later (“wait and see”) should be clearly documented.
Guidelines for Good Practice in Recording Clinical Practice (NMBI, 2015)

• Any information, instruction or advice given, including discharge advice, by a nurse/midwife, to a patient should be documented.

• All data written in respect of a patient/family should be kept in a designated area with a view to forming a complete single record.

• The patients/client’s name and record number (i.e. unique patient identifier) should appear on every page of the record.
Guidelines for Good Practice in Recording Clinical Practice (NMBI, 2015)

• Nurses/midwives should not, as a general rule, record or document care on behalf of someone else.

• The standard of record keeping of those under supervision in the clinical area e.g. student nurses/midwives or nurses/midwives undertaking supervised clinical practice prior to registration, should be monitored by the nurse/midwife charged with responsibility for the supervision or his/her delegate.

• Regular audit is an integral part of maintaining quality records.
References


References


