Accountability and information

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It appears that accountability, conduct and code are foremost in the minds of those interested in information. Health services everywhere are in the midst of profound structural change. No health service is stable. There are a number of key driving forces that will continue to transform the practice of medicine and nursing into the next century. Information technology is one of these key forces. As we look beyond the current changes in the National Health Service, the one thing that we know about the future is that will be different from now. We may be tired of change. We may even long for a period of stability, but this is not going to happen. Information technology combined with other technological advances will play a significant role in the delivery of future health care. The appropriate use of information technology, the application of computers and communications to the practice of medicine and nursing, and the coordination of care will be powerful. The delivery of healthcare is an information based activity. Yet we lag behind industry by many decades in the appropriate use of information technology.

It is my belief that by harnessing information technology, by combining powerful hand-held computers and patient data-bases, these tools will support the mobile nature of healthcare and provide a platform for new approaches to clinical practice in hospitals, the clinic and the home. All will be developed in the interests of patients and clients. The information revolution has changed the nature of our work and education.

One question is the implications of technology for nurses, midwives and health visitors, and other professions involved in the delivery of healthcare. This paper will concentrate on the implications and relevance for professional practice of two key words - accountability, and information.

Accountability

The power to do something inevitably carries with it the responsibility for doing it. Registered practitioners are accountable: able to be called to account for what was done. Accountability is an integral and essential element of professional practice for all those who become registered nurses, midwives or health visitors, as it is for other registered health professionals. Accountability extends to include omissions as well as actions, and other things which occur within the sphere of influence and
responsibility. Accountability extends to include the quality of delegation and acquiescence with the events around the practitioner.

Accountability is not easy. But the essence of professional practice is making judgements in a wide variety of circumstances and being able to be called to account for those judgements. In 1992 the UKCC published and distributed the third edition of "The Code of Professional Conduct for Nurses, Midwives and Health Visitors." This was a significant and important step towards the understanding of accountability. It was a document that was all about accountability, even though the word only appears in print once in the text. This deliberately brief document is making an equally deliberate big statement.

The Code of Professional Conduct

The Code of Professional Conduct makes a statement of the Council's expectations of people on the Register. It is a document which presents a portrait of the person Council believes we need and want to see in the profession. It is a yardstick or template against which practitioners can measure their conduct, knowing that if they become the subject of a complaint, Council will use it exactly in that way in considering the complaint. A statement of the premise of interests of those people, who often at times of greatest dependency are vulnerable and anxious and have no option but to place themselves in the hands of health professionals.

This document, from the point of view of the profession's regulatory body, spells out just what personal professional accountability involves. Some readers may have had the opportunity of hearing my colleague, Reg Pyne wax eloquently on the Code of Professional Conduct and accountability. He is constantly arguing that within the three professions we have certain expectations of the practitioners:

- practitioners will not silently tolerate the intolerable;
- practitioners will equip themselves to be articulate in representations about those things that obstruct the delivery of good care;
- practitioners will seek to set and maintain high standards and will expose those things that place patients at risk or jeopardise standards;
- practitioners will strive to maintain and improve knowledge and skill, for reasons that are self-evident;
- practitioners will choose truth rather than pretence;

Reg Pyne was quite clear that all these statements link firmly with the ethics of professional practice and each practitioners common law duty of care. He believes good conduct should involve being honest, open, questioning and challenging; because these are the qualities, together with knowledge and skills, that best serve the interests of the patients.

"Each registered nurse, midwife and health visitor shall act at all times in a manner such 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".
There can be no doubt about the individuals order of priority, or about whose interest he or she is meant to be serving.

The wording in the next piece of the Professional Code of Conduct provides the stem: the incomplete sentence out of which subsequent clauses grow and which in turn they complete. The only place in which the words 'accountable' and 'accountability' appear, but which in effect place them in each and every clause is the stem "As a registered nurse, midwife or health visitor you, are personally accountable for your practice and in exercising your professional accountability you must: ". I focus on the crucial importance and highly significant words - "...you are personally accountable for your practice". That hopefully, will finally convince practitioners that nobody else, be they medical practitioners, more senior colleagues or managers can bear your accountability for you. This is the only place in the document that is all about accountability. The words accountable and accountability appear only once, but the document is constructed so that effectively these words feature sixteen times. So if a clause is quoted without its stem it is detached from the words that emphasise that it must describe an aspect of personal professional accountability.

The stem sentence does not end with a permissive word, such as may or should, but with the mandatory 'must'. In this way the UKCC states its expectations of practitioners. It hardly needs to be argued that all clauses state aspects of accountability but four are particularly relevant: clauses 1, 2, 11 and 13. You must:

- always in such a manner as to promote and safeguard the interests and well-being of patients and clients (clause 1);
- ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, conditions or safety of patients and clients (clause 2);
- 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 would jeopardise standards of practice (clause 11);
- report to an appropriate person or authority where it appears that the health or safety of colleagues is at risk if such circumstances may compromise standards of practice and care (clause 13).

**Information and the recording of information**

A case study using information technology illustrates these last two clauses. The delivery of health care is based on information. As I undertake clinical visits throughout the United Kingdom an area of interest and concern is how nursing care information is recorded, either in paper format or using computerised information systems. There is a wide range of systems to facilitate electronic recording of patient or client information. The Council is extremely concerned with all types of information and how it is recorded. So much so that the Council produced in 1993 its Standards for Records and Record Keeping. The importance of making records is emphasised in the Council's Code and the Council's Guide for Students of Nursing and Midwifery. The UKCC expects that students, from the very beginning of their educational programmes, recognise the importance of accurate, comprehensive and up to date records and their role and responsibility in record keeping in the interests of patient care.
Setting standards for the professions

The reason for publishing the Standards for Records and Record Keeping was that there was a sufficient body of information that identified that variable standards of record keeping were occurring in recording patient care. The evidence that we used came predominantly from four sources.

The first was the evidence given before the Council's Professional Conduct Committee, meeting as the law requires in public. Time after time the cases which required to produce the records of patients, and which might be reasonably expected to provide evidence of the treatment and care given, had records which were found to be inadequate at best and at worst a disastrous failure of the practitioner's duty of care. The fact that medical records studied in these contexts were even worse than those made by nurses, midwives or health visitors should not be regarded as mitigation.

The second source was the evidence gleaned from published reports and sections of cases from the Health Service Commissioner. This was supplemented by the transcripts of proceedings before the House of Commons Select Committee to which he reports. Time after time this published material also focused attention on the existence of grossly inadequate records and in a failure of care, particularly in the continuity care which resulted. I am sure that both the Health Service Commissioner and his staff, like the UKCC and its officers, are not so deluded as to believe that only the bad cases are observed in the course of Professional Conduct Committee Hearings or the Commissioner's investigations. The fear is that they are all too typical and that something has to be done about it.

The third source of evidence providing strong support for something to be done was gleaned by my colleagues when they visited various parts of the United Kingdom in the course of their professional work. Many opportunities have been grasped to ask about record keeping systems and then to ask to be shown some of the current examples of records. Some of the records I have been shown in response to such requests have been very poor. They demonstrate the vulnerable situation they create for both the recipients and the givers of care.

The fourth source of evidence was that which came, and continues to come, unsolicited through telephone conversations and letters received by the Council from worried practitioners. Often, either newly qualified practitioners seeking to practice what they have been taught, or those that had moved to take up new positions and found in place approaches to record keeping which were alien to their previous good experience. They were being told they were worrying unnecessarily when they expressed their obviously well founded concerns. Such practitioners sought assurance that they were right to be concerned and to express that concern. Thus they became part of our evidence.

Case Study

Recently the Council received a letter highlighting concerns regarding a nursing information system that did not appear to adhere to the Council's standards for records and record keeping. The system appeared to contravene the Code of Professional Conduct. This fully integrated, nursing information system comprised a care planning module, rostering module, workload method, quality assurance facility and decision support. Fortunately, when commissioning the new information system, those
responsible undertook to test the system: entering test data, testing validity and reliability of the system to ensure that it matched the operational specification and requirements. One requirement was that the NIS must have a method of identifying the nurse who originated or updated any information maintaining the system, in order to identify the actual nurse at any time in case of an enquiry or complaint.

Whilst rigorously testing the system it was identified that once a nurse had completed an entry in the care plan and had exited from the system, another nurse could log on to the system, access the edit-item facility, go to any problem, goal or intervention within that care plan and add text to it, delete text from it, or totally change the whole and exit from the system. The summary care plan then showed all the changes that had occurred under the original nurse's identifier, time and date. The entry that the original nurse had made was not retained.

As was correctly identified by the test team the system was seriously flawed. As a result of this testing it was decided to stop using the care plan module for reasons of accountability of the practitioners and the potential litigation. The belief that the system was corrupt and that continued use of the system would contravene the standards set by the Council in its standards for record keeping and Code of Professional Conduct. This case study demonstrates an extremely serious situation. It exemplifies the sort of information that we receive and to which we respond.

Readers should note that the UKCC and the Department of Health, which is also concerned with nursing information systems, was subsequently assured by the software companies and suppliers of nursing information systems that the problems alluded to in the case study have been rectified, and that upgrades have been distributed to those using the information systems.

**Standards for Record Keeping**

The Council document states its reasons and provides it's justification for establishing standards in the first two paragraphs:

- the important activity of making and keeping records is essential and an 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 throughout.

In addition to being aware of the purpose of records, it is also important to make sure that the records are adequately maintained. The essential elements of records, to be effective and to meet standards, include:

- written legibly and indelibly;
- clear and unambiguous;
- accurate;
- each entry with the date and time;
- alterations made by scoring out with a single line followed by the initials, date and time corrected (on a computer that is a bit more difficult than on a hand-written record).
Within the context of the earlier care study, attention was drawn to two paragraphs: to ensure that alterations were made correctly and that there was a chronological order. They are both particularly important and sharply relevant to the case study. It cannot be accepted that entries made by one nurse can be deleted by another so that they disappear. To be replaced by the second person's entry, with the replacement entries appearing as if those of the first nurse, since they still bear that person's signature and the original date of entry. Something that would be totally unacceptable in a written manuscript record cannot be made acceptable by the use of information technology. There is no point in having a law that gives patients the right of access to records if these are not comprehensive.

Two final paragraphs in the 'Standards for Record Keeping': paragraphs 38 and 39 are relevant. Paragraph 38 states that the application of computer technology should not be allowed to breach the important principles 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 records to which they are expected to contribute important personal and confidential information. To illustrate this: about four weeks ago I was visiting a clinical area and asked the ward sister if it was possible to have a look at their nursing information system. She was delighted at my asking to see it. I asked her about levels of access. She said everyone had access. I queried that there must be different levels that individuals within the setting have access. "Oh no" she said, "It is not a problem, we are totally confidential about the information that we hold". Whereupon she told me the code word and the password. I asked when she was proposing to change her password. She said "We have used it for about a year and have not had any problems with it". It was an interesting password - one I would never have thought up for myself. Never the less it was accessible to absolutely everybody.

Paragraph 39 is also an important one, it says that where computer technology is employed it must provide a means of maintaining or enhancing service to patients and 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 to impede the compilation of sufficiently comprehensive records. The case for it has to be considered in association with the question of access, patients 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 identifier of the originator of that record.

From the information provided on the case study the nursing information study did breach the standards for records and record keeping.

Confidentiality of information

To trust another person with private and personal information is a significant matter. Patients and clients have expectations that professionals will exercise their judgement as to what information can be, or should be disclosed. Council states that neither technology nor management convenience should be allowed to determine principles. The practitioner must be satisfied in respect of the system for storage and movement of records opened in the health care setting to ensure that it is secure. Council has declared its policy on confidentiality and it is to be subsumed in a new compendium document 'Ethics for Professional Practice'.
The issue of confidentiality is also the subject of three major consultation documents. The first one comes from the Institute for Health Informatics at the University of Wales. The second is a multi-professional activity: seeking legislation through a private members bill, facilitated by the BMA and issued on 10th August 1994. The final one is coming from the Department of Health in England. It is a draft: 'Confidential Use and Disclosure of Personal Health Information'. It is interesting to observe that this was also published on 10th August 1994.

The discussion on security and the transfer of clinical records will continue for some time before the professions and the public reach a reasonable level of consensus. There are two factors influencing this debate:

- the growth in the use of information technology
- hazards to confidentiality resulting from the market in health.

I wish to acknowledge the encouragement and assistance which Reg Pyne has given me during the preparation of this paper.

References


UKCC. Standards for Records and Record Keeping. UKCC 1993.


Discussion

Elaine Stewart

I was very interested in the case study, I think I know to which system you referred. Did the UKCC arrange the testing?

Linda Thomson

The UKCC has no remit in the testing of individual systems. The procurement site had the responsibility to decide what needed to be done, they also had a great awareness of what they were expected to do in relation to their professional accountability.

It is also very important to ensure the rigour and testing of a particular system. To ensure that you put it through all the possible hoops within your mechanism. Then it
is a matter of being alert, on implementing a system, to any potential conflict that is not acting in the interest of patients. When this case study was brought to the UKCC we sought information from systems designers, from the software engineers and we are in the middle of gathering further information. When it is completed we will disseminate the information and publish our conclusions and disseminate them to appropriate interested parties. The Department of Health is also concerned with the robustness of nursing information systems, and is aware of the issues illustrated in the case study example.

Maggie Standley  
The Whittington Hospital, London

I also know which supplier you are talking about. I am concerned that the UKCC needs to take a firm stance in this sort of issue. There are a lot of hospitals which have already procured a system and are not in a position to make a decision as to putting this into their system requirements. The scenario of Wales turning off the care planning system happened at a very early stage. The credibility of using nursing information is already difficult to achieve. If we now have to take the same stance as Wales, having been using these systems for 18 months or longer, it does our credibility no good whatever. I think the UKCC has to take a very firm stance with all the suppliers. I do not believe the problem is unique to the system used in the case study. The suppliers of nursing systems need to address the problem as a matter of urgency.

Linda Thomson  
We were only alerted to this relatively recently. I will take your comments back to the UKCC.

Dr John Bryden  
Independent Public Health and Health Information Consultant, Glasgow

There is draft Council of Europe guidance and also almost the same kind of unwritten code of practice in Scotland that each institution should have one main health professional with personal responsibility for the overall control. Does the UKCC have any view on that? Is it likely to appear in UKCC guidance?

Linda Thomson  

Our locus is with individual practitioners. We set the standards for individual practitioners. Therefore we would not be looking at a larger group. We do not have a specific position on the subject.