

Principles

Janet Barker

Associate Professor; Director of Undergraduate Diploma/BSc (Hons) in Nursing, School of Nursing, Midwifery & Physiotherapy, University of Nottingham, UK

Jacqueline Randle

Associate Professor; Clinical Skills Lead for Masters of Nursing Science, School of Nursing, Midwifery & Physiotherapy, University of Nottingham, UK

Nursing and Midwifery Council (NMC)

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Nursing and Midwifery Council (NMC) standards of proficiency

Background

Standards of proficiency (previously known as ‘competencies’) are overarching principles that are considered central to safe and effective nursing practice. These standards were established in 2004 by the NMC and must be achieved by all those on the register of qualified nurses, midwives, and specialist community public health nurses. The standards set by the NMC apply to pre-registration nursing students.

Registered nurses, midwives, and specialist community public health nurses are expected to maintain their proficiency in relation to the standards, and they are expected to ensure their knowledge and skills are up to date and to the standard required for safe and effective practice. When renewing their registration, they are required to declare that they have met the post registration education and practice (PREP) requirements of the NMC. These requirements relate to two standards:

- PREP practice standard—registered nurses (RNs) must have worked, using their professional qualification, for a minimum of 450 hours in the previous 3-year period or undertaken a recognized return-to-practice course.
- PREP continuing professional development standard—they must have maintained a personal professional profile (PPP) recording of at least 35 hours of continuing professional development in the 3 years preceding re-registration.

RNs must comply with any request from the NMC to audit the PPP.

The standards of proficiency

Professional and ethical practice

- Manage oneself, one’s practice, and others in accordance with the NMC Code of Professional Conduct (2008), recognizing one’s own abilities and limitations.
- Practice in accordance with a legal and ethical framework, which ensures the primacy of patient interest and well-being and respects confidentiality.
- Practice in a fair and antidiscriminatory way, acknowledging the differences in beliefs and cultural practices of individuals and groups.

Care delivery

- Engage in, develop, and disengage from therapeutic relationships through the use of appropriate communication and interpersonal skills.
- Create and document a comprehensive, systematic, and accurate assessment of the physical, psychological, social, and spiritual needs of patients and communities.
- Formulate and document a plan of care, if possible in partnership with patients and their carers, family, and friends, within a framework of informed consent.
- Care should be delivered on the basis of the best available evidence—apply knowledge based on best available evidence and an appropriate repertoire of skills indicative of safe and effective practice.

- Evaluate and document the outcomes of interventions.
- Demonstrate sound clinical judgement across a range of differing professional and care-delivery settings.

Care management

- Contribute to public protection by creating and maintaining a safe environment of care through the use of quality assurance and risk-management strategies.
- Demonstrate knowledge of effective interprofessional working practices, which respect and use the contributions of others.
- Delegate duties to others, as appropriate, ensuring that they are supervised and monitored.
- Demonstrate key skills.

Personal and professional development

- Demonstrate a commitment to the need for continuing professional development and personal supervision activities, to enhance the knowledge, skills, values, and attitudes needed for safe and effective practice.
- Enhance the professional development and safe practice of others through peer support, leadership, supervision, and teaching.

Further reading

NMC Code of Professional Conduct (2008): <http://www.nmc-org.uk>.

Lifelong learning

Background

Evidence-based practice is an approach to the delivery of care aimed at ensuring all activities are based on rigorous evidence. The NMC Code of Conduct 2008 states that all care must be based on the best evidence available and reflect best practice. Pre-registration education provides a foundation for professional practice. However, practice is dynamic and there is a need to ensure registered nurses, midwives and specialist community public health nurses maintain and develop their proficiencies to meet the changing demands of health care through life long learning. This is more than simply keeping up to date, requiring a commitment to continuing professional development throughout your career as a HCW. NMC (2002) state that the principles of lifelong learning are central to professional practice and require all nurse to demonstrate these through various means.

Preceptorship

All newly qualified nurses are expected undertake a period of preceptorship (approximately 4 months) where a named, qualified nurse is identified to act as their supervisor, providing support and guidance during the transition from student to registered nurse.

Continuing professional development

PREP requirements require you to keep a portfolio of learning to demonstrate the continuing development of your knowledge and skills.

Clinical Supervision

Clinical supervision involves a skilled supervisor assisting a practitioner to reflect on practice facilitating problem-solving, on going learning and practice development. The NMC (2002) identify clinical supervision should be

- practice focussed supporting the improvement of care standards
- locally developed to meet local needs
- accessible to all nurse
- a formal, confidential process

NMC Supporting Nurses and Midwives through lifelong learning (2002)
<http://www.nmc-org.uk>

Responsibility and accountability

Background

'Responsibility' means to be obliged, being answerable for one's own actions a behaviour duty (NMC 2004)¹. All healthcare workers (HCWs) have individual and collective responsibilities to protect the patient and are legally accountable for their actions or inactions.

'Accountability' refers to the concept that individuals are responsible for their actions and may be asked to justify them (NMC 2008).²

If you are a pre-registration student, you will not be held professionally accountable by the Nursing and Midwifery Council (NMC), but you can be called to account by your university or the law for the consequences of your actions. The registered HCW you are working with is professionally accountable for your actions or inactions and this is why you must work under the supervision of a registered HCW.

Procedure: underlying principles

- All HCWs should protect and care for the vulnerable individual and act as an advocate for them, as appropriate.
- HCWs are liable to be called to account for their actions or omissions.
- HCWs should work within their own scope of professional skill and proficiency.
- Reasonable actions should be taken to avoid acts or omissions that can be foreseen.
- Care should be delivered according to evidence-based practice and reasonable standards.
- If concerns are raised, HCWs will be questioned about their practice.
- The patient and family, as appropriate, should be involved in decision-making, treatment, and care.
- Work should not be delegated to others unless you are confident about the ability of others to carry out the work proficiently.
- Interprofessional communication and working should be co-ordinated and encouraged.

1 NMC Code of Professional Conduct advice on delegation for registered nurses or midwives. (2004): <http://www.nmc-org.uk>.

2 NMC Code of Professional Conduct advice on accountability for registered nurses or midwives (2008): <http://www.nmc-org.uk>.

Consent

Background

- Before any form of care is undertaken, a patient must consent to treatment. 'Consent' refers to a patient's agreement for a healthcare worker (HCW) to provide treatment. Consent can be given in the following ways:
 - In writing
 - Verbally
 - Non-verbally

It is common practice for written consent to be obtained before surgery, complex treatments or procedures, and administration of a general anaesthetic or sedation if there are significant consequences for the patient's employment, social, or personal life or it is part of a research programme.

For consent to be valid, the following criteria must be met:

- Given by a competent person.
- Given voluntarily.
- Informed.

Procedure: underlying principles

- The best interests of the patient should be paramount, ensuring that consent is obtained before any care is provided.
- If for any reason a patient is unable to give consent (e.g. as the result of an accident or because they are unconscious), care can be provided if it is felt to be in the best interests of the patient or deemed to be life-saving (accounting for pre-existing instructions).
- All adults are deemed competent, unless identified as incompetent by an appropriately qualified HCW.
- Competent pregnant women may refuse treatment, even if the action causes harm to the unborn fetus.
- Children aged 16–17 years are able to give consent. Younger children in some circumstances can give consent if they fully understand the procedure, its consequences, and its risks.
- According to the Mental Capacity Act (2005), if an individual is shown to lack mental capacity, health professionals have a statutory duty to act in the best interests of the patient.
- Information should be provided in a clear and open way, recognizing that all patients have a right to receive information about their care, treatment, and condition and to be involved in decisions about their care.
- Patients need sufficient information to decide whether to give consent.
- Patients have the right to accept or decline treatment and care and their decisions should be respected.
- Patients can change their mind or withdraw their consent at any time.
- All actions relating to obtaining consent or refusal of consent should be documented.

Confidentiality

Background

Information concerning any patient is considered confidential and health-care workers (HCWs) have a duty to protect all patient information. In sharing personal information, the patient is demonstrating a high degree of trust, and any breach of this trust can seriously harm the HCW–patient relationship and have implications for the HCW's professional standing.

Procedure: underlying principles

- If information has to be shared with other HCWs, it is important that the patient is made aware of this.
- Information should not be shared with the patient's family or friends without first gaining consent of the patient. If for any reason a patient is incapable of giving such consent, this should be discussed with other HCWs.
- If consent to share information is refused or cannot be obtained for other reasons, information can be given in exceptional circumstances and only if it is in the public interest—to protect the patient or others from significant harm or required by law or order of a court.
- Before disclosing confidential information, it is advisable that you discuss the situation with senior HCWs, the Nursing and Midwifery Council (NMC), and/or your professional body.
- If a decision is taken to share confidential information, you will be held accountable for any disclosures and must be able to justify the actions taken.
- If you want to refer to a real-life situation in a written assignment, all information that could identify a patient should be removed.

Practice tip

- Beware in particular of breaching the confidentiality of celebrities and also other health care workers known within the practice setting.

Further reading

NMC Code of Professional Conduct (2008): <http://www.nmc-org.uk>.

Documentation

Background

Documentation is used to communicate the care provided and record any significant events. Documentation can function as evidence, to investigate a complaint or for criminal and other court proceedings, but it also has the following uses:

- Promotes high standards of care.
- Encourages continuity of care.
- Ensures good interprofessional communication.
- Provides detailed and accurate accounts of care delivery and management.
- Facilitates the detection of problems and monitoring of changes in the patient's condition.

Procedure: underlying principles

- You will be held accountable for what you write and record.
- Patients have a legal right to read their records. Information can only be withheld if it could seriously harm a patient or breaches the confidentiality of others.
- All documentation relating to patients must be kept securely and mechanisms must be in place to safeguard confidentiality.
- Professional judgement must be used when identifying the relevant information to record and frequency of entries.
- Records should be accurate, clearly written in black indelible ink (in terms that are easily understandable), dated (including the time) and signed, contain only relevant information, and exclude jargon, abbreviations, or offensive subjective statements. Documentation written by students should be countersigned by the qualified nurse supervising the student.
- Records should provide clear and full accounts of assessments and plans of care, appropriate information relating to the condition of the patient and the nature of interventions provided, evidence of safe and accountable practice, accounts of the arrangements for continuity of care, and evidence of patient involvement, as appropriate. In a court of law, care is not considered to have been given unless it has been documented.
- The names, designations and ideally bleep/pager numbers of health care workers involved in management decisions should be recorded in the patient records.
- Documentation should be regularly audited to ensure the required standards are achieved and areas for improvement are identified.



Legal frameworks and policies

Background

Healthcare workers (HCWs) are answerable for their actions and must be aware of their limits and powers in relation to the delivery of care. HCWs are required to ensure their practice is lawful, by being aware of legislation and local protocols that relate to care delivery.

Law

There are two sources of law:

- **Acts of Parliament and statutory instruments**—these are statutory requirements, such as the Care Standards Act (2000), Health Act (2006), Mental Incapacity Act (2005), and Disability Act (1998).
- **Common law**—this relates to individual judgments or interpretations in relation to statute law and the precedence these set in relation to statute law.

Policy

Policy provides guidance in relation to the activities undertaken in a particular setting. In the health care setting, two types of policies are in evidence: national and local.

The Government, through the Department of Health (DoH), provides the legislation and national policy relating to how the National Health Service (NHS) is structured, financed, and managed. The DoH also sets standards against which care provision will be measured. This, in turn, is interpreted in light of local needs and services, resulting in local policy, which provides guidance on how NHS trusts should implement health legislation and policy, operationalize standards of care, and develop practice protocols and policies. Policies change over time and may vary from organization to organization. Therefore it is important that your knowledge remains current and that you familiarize yourself with the policies relating to the organization within which you practise.

Standard-setting

Clinical governance

Clinical governance is advocated to ensure that quality health care is provided in an effective way. It aims to promote formal reporting and accountability systems, clinical audit, and clinical effectiveness. These are termed 'quality assurance and improvement approaches' and promote standard setting and evidence-based practice.

National Institute for Health and Clinical Excellence (NICE)

NICE is an independent organization commissioned by the Government to produce national standards in relation to specific areas of care. Using expert panels, NICE develops guidelines for best clinical practice and benchmarks for best practice.

National Service Frameworks (NSFs)

NSFs provide national standards for specific areas of care and identify goals to be achieved within set timeframes. NSFs are currently available for the following areas:

- Coronary heart disease.
- Cancer.
- Paediatric intensive care.
- Mental health.
- Older people.
- Diabetes.
- Long-term conditions.
- Renal services.
- Children.
- Chronic obstructive airway disease.

Health and safety

Background

The environment in which healthcare workers (HCWs) practise must, by law, be safe for both staff and patients. Each HCW has a responsibility for ensuring the safety of the environment in which they practise, minimizing the risk to others, and should be aware of health and safety legislation. The requirements for health and safety issues are usually found in three types of documents: regulations, guidance, and approved codes of practice (ACOPs).

Regulations

The Health and Safety at Work Act (1974) provides the basis for British law in this area, specifying the duties of employers and employees in maintaining a safe working environment. Further regulations have been added that outline the responsibilities placed on employers in relation to the management of health and safety issues. The main requirement outlined in these regulations is systematic risk assessments of work activities for the following reasons:

- To identify hazards.
- To identify who is at risk.
- To evaluate risk.
- To identify methods of managing risk.
- To record assessment.

Guidance

The Health and Safety Executive (HSE) provides guidance in relation to specific health and safety problems and general processes across a range of areas. The main purpose of the guidance is as follows:

- To help people interpret and understand the regulations.
- To help people adhere to the legal requirements.
- To provide technical advice.
- To provide a way of ensuring that legal requirements are met, although following the guidance is not compulsory.

ACOPs

These provide practical examples and advice on how the regulations can be met.

Untoward incidents

Background

All health care environments must have a system for reporting and investigating untoward incidents. According to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (1985; RIDDORs), the Environmental Health department of the local authority must be notified in the following situations:

- Fatal injuries to employees or other people in an accident connected with the area.
- Major injuries to employees or other people.
- Any of the dangerous occurrences listed in the regulations.
- Any other injury to an employee that results in an absence from work for more than 3 days.
- Any cases of ill health resulting from exposure to toxic chemicals, occupational asthma, or any illness caused by a pathogen.

Procedure: underlying principles

- Reporting and recording untoward incidents is vital—it is considered as providing information that enables trends and management interventions to be identified.
- The procedure identified for recording such incidents must be followed and usually involves:
 - Reporting accidents or untoward incidents to the senior manager.
 - Completing an incident form.
 - Notifying the Health and Safety Officer
- An untoward incident form must include the following details:
 - Date of the report.
 - Date, time, and place of the incident.
 - Personal details of those involved.
 - Brief description of the event or incident and actions taken.

