Newly qualified nurse responsibilities

ASSIGN BUSTER

The aim of this assignment is to discuss the global roles and responsibilities of the newly qualified nurse. The exercise will begin by briefly looking at the transition from student to nurse and thereafter outlining the basic roles of the newly qualified nurse and try to fit them into appropriate professional skills. In addition, there will be a critical examination of two roles in more detail with one of them focusing on Patient Group Directions (PGD), and justify their importance. We will then look at some legal, professional and ethical considerations before making a conclusion on the future role development of the nurse.

The NMC require a student nurse to demonstrate professional and ethical practice, be competent in care delivery and care management, and show personal and professional development in order to join the register (NMC, 2010). On becoming a qualified nurse, the expectations and dynamics of relationships changes fundamentally. Suddenly the newly qualified nurse is the one who must ‘ know the answer’, whether it is a query from a patient, a carer, a work colleague or a student. The newly qualified nurse will encounter many challenging situations where she or he must lead care delivery. This includes dealing with care management within the team, dealing with patients/service users, dealing with other professionals, and dealing with the required needs of the whole workplace environment.

These changes require a large shift from the experience of being a student and a mentored supervised learner, so it is essential that one is equipped with all the skills required to successfully make the transition. The newly qualified nurse must demonstrate they are fit to enter the NMC register and

therefore be eligible to practice as a qualified nurse. In all cases, the newly qualified nurse is seen as:

Provider of care

Educator

Counsellor

Collaborator

Researcher

Change Agent

Patient Advocate

Manager

The above are typically the roles of a newly qualified nurse which can be compressed into the NMC professional skills requirements listed below:

Maintaining standards of care

Making ethical and legal decisions

Being accountable

Teamworking

Teaching others

Being in charge.

It is recognized that there is a certain amount of overlap in these professional skills and that some concepts cross all of them, in that there are no clear lines drawn where one skill ends and another starts. For the purpose of this analysis, we will look at the issue of making ethical and legal decisions and the Patient Group Direction.

Decisions and actions are taken by nurses in the course of day-to-day practice. One would not usually consider each of the skills or concepts in isolation in relation to particular incidents but would make a decision based on the factors contributing to the situation. However, when analysing any situation, in the decisions made and the actions taken, some of the individual conceptual principles may be recognized and highlighted. For example, asking a member of staff to complete a task on your behalf is delegating. This fits neatly into leadership theory and also relates to aspects of accountability. Completing a health and safety audit in the work environment might relate to management theory and responsibility taken on. Completing a review of an individual’s care and setting goals for them in multidisciplinary meetings might relate to team working theory. Reporting of poor practices or environments might relate to aspects of accountability and maintaining standards of care.

However, all of the above aspects could arise from analysing one situation where the nurse has to make decisions about a certain aspect of care management thus emphasizing the great importance of making ethical and legal decisions.

DECISION MAKING PROCESS

Nurses are problem solvers who use the nursing process as their tool. The chief goal of ethical decision-making process is to determine right and wrong in situations where clear demarcations are not apparent, and then search for the best answer. For a newly qualified nurse, the following will be a guide to making ethical decisions:

State the Dilemma – State dilemma clearly, determine whether the problem/decision involves the nurse or only the patient, focus attention on ethical principles and follow the client's wishes first while considering the family input in case of unconsciousness.

Collect and Analyze Data – Know client's and family's wishes and all information about the problem. Keep abreast of any up to date legal and ethical issues; which may also overlap.

Consider Choices of Action – Most ethical dilemmas have multiple solutions, some of which are more feasible than others. The more options that are identified, the more likely it is that an acceptable solution can be identified. It may require input from outside sources and other professionals such as Social workers etc.

Make the Decision – The most difficult part of the process is making the decision, following through with the action, and then living with the consequences. Ethical dilemmas produce differences of opinion and not every one is pleased with the decision but it must be emphasized that client's wishes always supercede the decision by health care providers but

ideally, a collaborative decision is made by client, family, doctor and nurse thus producing fewer complications.

Act – Once a course of action has been determined, the decision must be carried out. Implementing the decision usually involves collaboration with others.

Evaluate – Unexpected outcomes are common in crisis situations that result in ethical dilemmas. It is important for decision makers to determine the impact an immediate decision may have on future ones. It is also important to consider whether a different course of action might have resulted in a better outcome. If the outcome accomplished its purpose, the ethical dilemma should be resolved and if the dilemma has not been resolved, additional deliberation is needed.

Patient Group Direction (PGD)

The legislation (Statutory Instrument, 200a) states that ‘ Patient Group Direction means – in connection with the supply of a prescription only medicine… a written direction relating to the supply and administration of a description or class of prescription only medicine… or a written direction relating to the administration of a description or class of description only medicine, and which in the case of either is signed by a doctor… and by a pharmacist; and relates to the supply and administration, or to administration, to persons generally (subject to any exclusions which may be set out in the Direction).’

In practice this means that a PGD, signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse to supply and/or administer

prescription-only medicines (POMs) to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription.

When can PGDs be used?

The law is clear that the majority of care should be provided on an individual, patient-specific basis, and that the supply and administration of medicines under PGDs should be reserved for those situations where this offers an advantage for patient care (without compromising safety), and where it is consistent with appropriate professional relationships and accountability. The RCN interprets this to mean that PGDs should only be used to supply and/or administer POMs to homogeneous patient groups where presenting characteristics and requirements are sufficiently consistent for them to be included in the PGD e. g. infants and children requiring immunisation as part of a national programme.

Which POMs can be supplied or administered under a PGD?

PGDs can be used to supply and administer a wide range of POMs although there are currently legislative and ‘ good practice’ restrictions in relation to controlled drugs, antimicrobials and black triangle drugs.

Controlled drugs – The use of controlled drugs continues to be regulated under the Misuse of Drugs Act 1971 and associated regulations made under that Act. The Home Office has agreed to allow the supply and administration of substances on Schedule 4 (with the exclusion of anabolic steroids) and all substances on schedule 5 to be included in PGDs.

Antimicrobials – can be included within a PGD but consideration must be given to the risk of increased resistance within the general community. When seeking to draw up a PGD for antimicrobials, a local microbiologist should be involved and approval sought from the drug and therapeutics committee or equivalent.

Black triangle drugs and medicines used outside the terms of the Summary of Product Characteristics

Black triangle drugs (i. e. those recently licensed and subject to special reporting arrangements for adverse reactions) and medicines used outside the terms of the Summary of Product Characteristics (SPC) – sometimes called ‘ off label use’ (for example, as used in some areas of specialist paediatric care) may be included in PGDs. Their use should be exceptional and justified by best clinical practice, and a direction should clearly describe the status of the products.

How should PGDs be drawn up?

The law (Statutory Instrument, 2000a) requires that PGDs should be drawn up by a pharmacist and the doctor who works with the nurses who will be using them. The relevant health authority should also ratify the PGD. In England, when PGDs are developed locally, HSC 2000/026 (NHSE, 2000) requires that a senior doctor and a senior pharmacist sign them off with authorisation from the appropriate health organisation, i. e. the trust, and that all nurses using the directions are specifically named within the PGD and signed by them. The RCN acknowledges this as good practice and recommends the following steps be taken throughout the UK.

The NMC Standards for Medicines Management (2007) state that ‘ the administration of drugs via PGD’s may not be delegated and students cannot supply or administer under a PGD. Students would however be expected to understand the principles and be involved in the process’ (NMC 2007).

Failure to ascertain that a PGD is the most appropriate route can lead to waste of valuable time and resource and place increased risk on delivery and quality of patient care. Anyone involved with PGDs (whether developing, authorising or practising under them) should understand the scope and limitations of PGDs as well as the wider context into which they fit to ensure safe, effective services for patients.

Any extension to professional roles with regard to administration and supply of medicines must take into account the need to protect patient safety, ensure continuity of care and safeguard patient choice and convenience. It also has to be cost effective and bring demonstrable benefits to patient care.

Any practice requiring a PGD that fails to comply with the criteria falls outside of the Law and could result in criminal prosecution under the Medicines Act.

With regard to the written instruction required for the supply and administration of medicines by non-professionals, Medicines Matters (2006) (3) clarifies that a suitably trained non-professional member of staff can only administer medicines under a Patient Specific Direction (PSD).

Medicine Matters (2006) states that: “ Patient Specific Direction is the traditional written instruction, from a doctor, dentist, nurse or pharmacist

independent prescriber, for medicines to be supplied or administered to a named patient. The majority of medicines are still supplied or administered using this process."

There is nothing in legislation to prevent PSDs being used to administer medicines to several named patients e. g. on a clinic list. PSDs are a direct instruction and therefore do not require an assessment of the patient by the health care professional instructed to supply or administer the medicine.

Pharmacy Only (P) and General Sales List (GSL) Medicines

Medicines legislation states that a PGD is not required to administer a P or GSL medicine. The use of a simple protocol is advisable for best practice and from a governance perspective. All medicines administered must be recorded in the patient's medical record. Where a GSL medicine is to be supplied it must be taken from lockable premises and supplied in a pre-pack which is fully labelled and meets the GSL requirements. A PGD will be necessary for the supply of P medicines by anyone other than a registered pharmacist. Recommend further advice to be sought from a pharmacist. (Ref: NPC PGDs 2004).

For safe administration of drugs, the newly qualified nurse must give the right dose of the right drug to the right patient in the right route at the right time. When giving medications, the nurse needs to be aware of possible interactions between the patient's different drugs. It is the nurse's responsibility to protect the patient from harm. If they think the wrong drug or the wrong dose has been ordered, they must ask for help from the nurse or the doctor in charge. The newly qualified nurse needs to know the doses

of the drug which are safe to administer. Sometimes the pharmacy gives out drugs in grams when the order specifies milligrams, or the other way around. They need to know how to convert these.

It is important to know what types of dilemmas newly qualified nurses may face during their careers and how they may deal with it. It is also important for nurses to understand what malpractice is and how they may protect themselves from a malpractice suit. Firstly, it is important to understand the difference between law and ethics. Ethics examines the values and actions of people. Often times, there is no one right course of action when one is faced with an ethical dilemma. On the other hand, laws are binding rules of conduct. When laws are broken, it is punishable by an authority.

There are four types of situations that pertain to law and ethics. The first would be an action that is both legal and ethical. An example of this would be a nurse carrying out appropriate doctor’s orders as

ordered. A nurse may also be faced with an action that may be ethical but not legal, such as allowing a cancer patient to smoke marijuana for medicinal purposes. The opposite may arise where an action may be legal but not ethical. Finally, an action may be neither legal nor ethical. For example, when a nurse makes a medication error and does not take responsibility to report to it appropriately.

The right of service users to expect practitioners to act in their best interests is reinforced by professional codes of conduct and legislation such as the Mental Health Act. It is also reflected in equality of opportunity legislations such as the Sex Discrimination Act and the Race Relation Act, which aim to

ensure that everybody has equal access to and is offered equal care by health and social care service.

Patient’s right to confidentiality under statutory duties is stipulated in the Data Protection Act, Article 8 European Convention of Human Rights, Access to Personal Files Act 1987 and Access to Health Record Acts 1990. The code does require that nurses must disclose information if they believe someone may be at risk of harm in line with the law.

As a nurse, respecting autonomy means you must effectively communicate with patients, be truthful, enable patients to make decisions freely, provide appropriate information and accept the patient’s preferences. Legally, patients must be given enough information to make a balanced judgement however we must be aware that if nurses fail to comply with the legal duty of disclosure, they could face a negligence claim. However, under the principle of therapeutic privilege they can legally withhold information that they think will harm the patient

Some patients whether children or adults are unable either to make or to communicate their decisions therefore they lack (or have limited) capacity. The Mental Capacity Act 2005 that create and clarifies the common law on consent in England and Wales, affects everyone aged 16 and over, and provides a statutory framework to empower and protect people who may not be able to make some decisions for themselves.

The moral justifications for acting without consent are the principles of beneficence (the duty to do good) and non-maleficence (the duty to do no harm). Paternalism is overriding someone’s autonomy because you think it is

for their own good. However, it is justifiable if we can demonstrate that the patient is at risk of significant, preventable harm, or the action will probably prevent the harm, or the patient's capacity for rational reflection is either absent or significantly impaired, or at a later time, it can be assumed that the patient will approve of the decision taken on his/her behalf, or the benefits to the patient of intervention outweigh the risks.

Also, we live in a society where demands for accountability and taking responsibility are so commonplace that pinning the blame on someone or something has become almost a fad. The NHS' culture of blame has developed basically because no one wants to be accountable or responsible for actions or omissions hence there are no longer any accidents or mistakes. Principles of beneficence and non-maleficence underpin the concept of fault – which lies at the heart of negligence law.

Beneficence means that you must act in ways that benefit others (i. e. duty to care), and Non-maleficence means that you have a duty not to harm others nor subject them to risk of harm. Every nursing intervention that aims to benefit patients may at the same time also harm them. Sometimes the harm will be unavoidable or even intentional and at other times it can be unintentional and unexpected, therefore it is appropriate to think about the principles of non-maleficence and beneficence together in order to balance harm and benefits against each other. We can resolve this problem responsibility and accountability. These words are sometimes used interchangeably because they do overlap but in actual fact they do not mean the same thing.

Being responsible can mean that it is your job or role to deal with something and/or that you have caused something to happen. Accountability on the other hand is about justifying your action or omissions and establishing whether there are good enough reasons for acting in the way you did.

Even where the newly qualified nurse delegate tasks to others, such as nursing auxiliaries or care assistants she/he is accountable to the patients through a duty of care, underpinned by a common-law duty to promote safety and efficiency, and legal responsibility through civil law, the employer as defined by your contract of employment, the profession as stated in the relevant codes of conduct and the public.

Conclusion

All newly qualified nurses were faced with assumptions from others that they should ‘ know everything’. This was also a high expectation they had of themselves. In meeting the NMC standards of proficiency the nurse should have demonstrated the relevant knowledge and skills in order to practise in their relevant specialized fields. However, it is important to recognize that not every nurse knows everything about everything in their field, especially if they are practising in highly specialized fields. What they need is to be able to develop and adapt to changing situations. Therefore, for the nurse it is impossible to know everything, but they should have developed the skills to find out relevant information, reflect on it, and apply this to their practice. In essence they should have learned how to learn. There is a great deal to be learned once qualified, especially related to a nurse’s ‘ new’ area of work and a good deal of the development needs to take place ‘ on the job’.