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Science

Introduction

The focus of this assignment is to increase our awareness of the professional, ethical and legal issues that are associated with providing accountablehealthand social care. Once groups were formulated, and the scenario was decided, the group could discuss and draw focus areas both as a group and individually. A learning journal was kept using diary sheets which documented what was discussed. The scenario that was chosen by the group was Eddie, based on the numerous ethical issues that arose. This assignment is going to concentrate on the issue of record keeping, and the way it impacts on the role of the accountable practitioner. As part of adultnursingthere are various forms of record keeping that exists and the Nursing and Midwifery Council (NMC) (2009) stipulates good record keeping is a fundamental element of nursing practice, and is crucial to safe and effectual care.

The NMC (2009) guidance for record keeping also specifies that your records should be accurate and recorded in such a way that the meaning is clear and you have a duty to communicate effectively with your colleagues. This was not present throughout this scenario as the constant lack misunderstandings andcommunicationerrors are what lead to the medication errors being made, resulting in actual harm to this patient.

Caulfield (2005) talks about a framework ofaccountabilitybased on four pillars, professional, ethical, legal and employment accountability, which takes into account our different understandings as to what accountability is all about. The key pillar within this is the presence of professional

accountability, which is a fundamental aspect of nursing and sanctions nurses to work within a structure of practice and follow standards of conduct that preserve the patients trust. Its manifestation spearheaded the creation of our standards of conduct that exists within our governing body the NMC today.

Accountability

Accountability in terms of record keeping is the facilitation of good governance. There is no solitary source of accountability, as different organisations create different principles and guidelines. As a registered nurse we are obligated and duty-bound by a particular set of standards that govern our profession, this gives us our boundaries and restrictions in which we must work. This is supported by Griffith and Tengnah (2010) which acknowledge that as a registered nurse you will be lawfully and professionally answerable for your behaviour regardless of whether a person is following directives from another individual or using their own ingenuity.

Accountability is often seen in practice as a rationalisation of ones actions, specifically in terms of distributing the blame. Blame Mentality can be destructive can often lead to a pessimistic view of accountability and its application in caring for patients and espousing staff (Scrivener, Hand and Hooper, 2011). However one definition that adds a more positive facet view on accountability is that “ it is an inherent confidence as a professional that allows a nurse to take pride in being transparent about the way he or she has carried out their practice” (Caulfield, 2005, p. 3).

There are systems that are put into place throughout our workplace, these can often govern the care we give our patients; it can also have an impact on the quality in which we deliver this care. However despite this professional accountability is an individualresponsibilitythat is also parallel withduty of carein law. Our governing body of nursing regards professional responsibility and accountability to be at the core of high quality nursing. Neglect, medication errors, poor record keeping and communication problems are the commonest issues, and all told account for almost 60% of cases heard before the fitness to practice panel (NMC, 2010a). This report also identified record keeping as the fourth most common allegation in fitness to practice cases, which is why the current record keeping guidance in place by NMC, is under review.

As this report has shown there is definitely a lack of value to documentation shown by nurses, this is perhaps because nurses may feel it is too time consuming and takes away the time we need for our patients. There is also perhaps a negative perception in terms of the importance of record keeping. However the public and our patients expect nurses to be working to a certain level of competence and high standards. This is why the Royal College of Nursing (2010) drew up principles of nursing practice, and within this they stipulate that nurses should take responsibility for the care they carry out, and answer for their own judgements and action. This is to be carried out in accordance with the law and our professional governing body. These principles incorporate the thesis of accountability. In terms of record keeping the principles suggest that nurses are pivotal to the communication process, this is due to recording and reporting on treatment and care that is required.

Information that is not available or written can have an influence on the practice that other healthcare professionals give and the effectiveness of that practice.

As the registered nurses role expands, their responsibility becomes greater and so does the level of risk management and legal accountability. Once a healthcare worker adopts obligation for care of a patient, they are legally bound to this through duty of care. This can apply when performing complex tasks or more straightforward tasks such as record keeping. Additionally, where the task has been delegated by another healthcare professional or more senior practitioner, on whom overall accountability lies; there is also a duty of care that lies with that individual to delegate appropriately and effectively. This is mirrored by the NMC (2008) standards of conduct and other care professional organisations.

Also in relation to accountability the Essence of Care (2010) document benchmarks best practice required for record keeping. It specifies that staff to be competent to generate, use and sustain care records, together with the aptitude to keep precise, comprehensive care records.

Ethics

Ethics is aphilosophywhich determines right and wrong in relation to a person’s decisions or actions. However in nursing this can often compete with other realities and pressures, such as time constraints and the increasing responsibilities that are put upon nurses, such as record keeping. How we interpret ethics is individual, like our morals and beliefs, however ethics are universal and is often implied within our laws and standards of

practice. Our governing body the NMC does not mention anything precisely in relation to ethics within the code of conduct, but implies it through the standards and rules that they have set in place.

One major ethical issue is that of confidentiality. The Caldicott Report (1997 cited by Department of Health (DOH) 1998) recognised flaws in the way parts of the NHS conducted confidential patient records. They had worries about the quantity of personal material that was being moved and the competence of the of NHS to create a boundary, in which this information was only accessed by those that needed to know. The Caldicott Committee made numerous recommendations and focused on initialising certain frameworks to avoid this occurring. Part of this was to hold NHS organisations responsible for bettering their confidentiality systems and confidentiality breaches. Good record keeping will play a key role in achieving this. They did this by setting out six key principles, which entails justifying the purpose in which you are using that information, not to use that information unless necessary and keep the usage to a minimum, and you should be aware of the responsibilities you have when accessing that information and understand and obey the law (DOH, 2010).

However, although maintaining and protecting patient’s privacy and confidentiality is a matter of law and is governed by our regulating body of nursing. The Royal College Nursing (2009) thinks that distributing data about patients, taking into account safeguarding, is a vital part of nursing and is important for multi-disciplinary treatment.

It is not just a case of one person providing all the care needed every time, and the communication of important information to other health professional is central in relation patient safety and continuity of care. In order to provide this continuity it is vital that record keeping be precise and exact.

Beauchamp and Childress (2008) offer four principles that they believe can structure a guide in ethical decision-making; Autonomy, Non-maleficence, Beneficence and Justice. They consider these four principles to lie at the core of nursing and health care.

Non-Maleficence requires that no harm be caused to any patient either intentionally or deliberately. However non-maleficence is not an ethical value on its own, but a concept incorporated by the ethics of beneficence. Not doing harm inevitably means you are doing good . Poor recording keeping could be deemed as clinical negligence and therefore is a breach of duty of care and could lead to harm of a patient. The NMC (2010b) regards safeguarding as part of daily nursing practice so therefore, as a nurse in these environments you should have the skills to realise when something is inappropriate, this could be where an individual in your care is at risk of injury, mistreatment or neglect, including poor practice.

This is also the ethical issue in relation to autonomy within record keeping. This gives the patient to freedom to make their own decisions, and in terms of record keeping patients have access to the material they want, to make decisions about their care. They have more control over their own care records. The NHS PublishedEqualityand Excellence (2010) specifying that

this is empowering and enabling patients to discuss their care with nurses and get involved in decision making.

Justice is about treating individuals fairly and equally and requires nurses to be non- judgemental.

Justice is also a concept of fairness. Seedhouse (2009) suggests that there three versions of fairness in justice which are part the overall notion of justice, these are to each according to his rights, what he deserves, and according to his need. Based upon this it is important in record keeping to remember that we must record an evaluation of care that is individual to the patient. It is about our professional judgement on this patient not our personal one.

Law

The law does not generally advocate who should perform what role or tasks we perform, although there are numerous exceptions, the law does however compel a registered practitioner to abide by a duty of care. This is applies to any healthcare worker that could potentially cause harm to a patient. Once a law is enforced there is a certain standard of care expected of nurses performing certain duties or tasks, like record keeping. The legal standard is appraised by that of a conventional skilled practitioner performing that task or role (Cox, 2010). In relation to particular tasks such as record keeping the courts will apply common sense in establishing the appropriate standard needed. Poor record keeping are inexcusable by the standards of any rational individual. A health professional’s record keeping is the only legal form communication that can be used as evidence of care taking place.

Effective record keeping protects a nurse from having to give testimony of their professional accountability. The courts adopt the attitude that if an action has not been recorded it has simply not taken place (Owen, 2005).

Often in circumstances such as discrepancies within record keeping the Bolam Test can be used. The Bolam Test (1957 cited by Robertson 1981) was introduced to establish principles of professional practice, this can be used to judge as to whether any defects or errors have been made, which could have lead to the suffering or harm to that patient.

There is numerous legislation within nursing that govern our power and limitations, particularly in relation to the handling and processing of information, which impacts upon record keeping in the process. One key legislation is that of the Data Protection Act (1998). This is the main act in the United Kingdom that protects our personal data and controls the handling of that personal data for both patients and staff. The act requires a healthcare professional to obey the eight principles, in which it encourages equality and honesty when handling particular information. These principles are also there to ensure that data is processed lawfully in accordance with the act.

Another piece of legislation that applies to record keeping is the NHS Code of Practice. The Department of Health NHS Code of Practice (2003, p. 7) states that “ a duty of confidence arises when one person discloses information to another in circumstances where it is reasonable to expect that the information will be held in confidence. It is a legal obligation that is derived

from case law; and is a requirement established within professional codes of conduct".

Our NMC (2008) code of conduct is underpinned by law. It requires us as registered nurses to act lawfully, whether those laws apply to either our professional practice or personal life.

Information governance plays a big part within record keeping. Information governance is comprised of a set of principles that the National Health Service (NHS) has to obey to make ensure they maintain complete and precise records of care. They must also keep there records confidential, protected and accurate. This is where the NHS Care Record Guarantee comes in Play. It explains the NHS promise, which is to only use patient's records in a way that is respectful to their rights and promotes their health and well being. The guarantee ensures that the people who care for our records maintain them in a confidential, secure and accurate manor and to provide information that can be accessed easily (NHS, 2005).

TheHuman RightsAct (1998) exists to protect ourcivil rightsin the United Kingdom (UK) and to increase our understanding of the basic principles and values we share. Anyone in the UK for any reason has elemental human rights. Article 8 of that act, the right torespectfor private andfamilylife, is the most relevant in terms of information governance within record keeping. Article 8 reflects the common law duty of confidentiality. If data is inaptly divulged, the person can take legal action. Patient information must be held confidentially and securely.

Conclusion

In conclusion accountability, ethics and the law are a fundamental and integral part of nursing. Focusing on these key matters helps establish boundaries and principles, in which we can apply to become safer and more competent accountable practitioners

Our duty of care bounds us legally and ethically, and also through accountability, to provide accurate record keeping throughout our healthcare system. This is why an awareness of professional codes of practice, ethical decision making and an understanding of accountability and anti-discriminatory concepts, will help strengthen a nurse’s ability to provide impeccable record keeping.

The benefits to good record keeping means that patient care will be consistent and that is not compromised. Both registered nurses and student nurses need to be supported and urged to regard record keeping as having a constructive impact of a patient’s care, rather then just an inconvenience that has to be endured.