

United Kingdom Central Council for Nursing, Midwifery and Health Visiting

EXERCISING ACCOUNTABILITY

A framework to assist
nurses, midwives
and health visitors to
consider ethical
aspects of professional
practice.

UKCC

United Kingdom
Central Council
for Nursing,
Midwifery and
Health Visiting
23 Portland Place
London W1N 3AF
Tel: [REDACTED]

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A UKCC
Advisory Document

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This is the 4th document in a series to supplement the Code of Professional Conduct for the Nurse, Midwife and Health Visitor. (Second Edition; November 1984).

In the text that follows the use of the feminine gender equally implies the male and similarly the use of the male gender equally implies the female.

The word "Practitioner" in this document means a registered nurse, midwife or health visitor. Where reference is made to a practitioner from another profession it is indicated by the relevant prefix.

The contents of this Advisory Paper are relevant to all persons whose names appear on any part of the Professional Register maintained by the UKCC and will be of special interest to those undertaking courses of education and training with a view to admission to the Register.

In order to understand fully the issues addressed it is essential that the advisory paper should be read in its entirety.

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A. Introduction

1. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting regulates the nursing, midwifery and health visiting professions in the public interest.

The UKCC was established by the Nurses, Midwives and Health Visitors Act 1979.

Section 2(1) of the Nurses, Midwives and Health Visitors Act 1979 states that **'The principal functions of the Central Council shall be to establish and improve standards of training and professional conduct'**.

Section 2(5) of the same Act moves from the requirement to improve conduct to one of the methods to be employed when it states that **'The powers of the Council shall include that of providing in such manner as it thinks fit, advice for nurses, midwives and health visitors on standards of professional conduct'**.

2. The Code of Professional Conduct for the Nurse, Midwife and Health Visitor is the Council's definitive advice on professional conduct to its practitioners. In this extremely important document practitioners on the UKCC's register find a clear and unequivocal statement as to what their regulatory body expects of them. It therefore also provides the backcloth against which any alleged misconduct on their part will be judged.

The Code of Professional Conduct is considered to be

a statement to the profession of the primacy of the interests of the patient or client.

a statement of the profession's values.

a portrait of the practitioner which the Council believes to be needed and which the Council wishes to see within the profession.

3. The Council has already published three advisory documents to supplement the Code of Professional Conduct. Practitioners now seek:

- (i) elaboration of clauses 10 & 11 of the Code and support for their position when doing as these clauses require. These Clauses state that:-

'Each registered nurse, midwife and health visitor is accountable for his or her practice and, in the exercise of professional accountability, shall:-

10. Have regard to the environment of care and its physical, psychological and social effects on patients/clients, and also to the adequacy of resources, and make known to appropriate persons or authorities any circumstances which could place patients/clients in jeopardy

or which militate against safe standards of practice.

11. Have regard to the workload of and the pressures on professional colleagues and subordinates and take appropriate action if these are seen to be such as to constitute abuse of the individual practitioner and/or to jeopardise safe standards of practice'.

- (ii) advice and guidance on issues related to consent and the general subject of truth telling.
- (iii) advice and guidance on that part of the practitioner's role which concerns advocacy on behalf of patients and clients.
- (iv) elaboration of clause 5 of the Code which states that each registered nurse, midwife and health visitor shall:
- 5. 'Work in a collaborative and co-operative manner with other health care professionals and recognise and respect their particular contributions within the health care team'.**
- (v) advice and guidance on issue related to contentious treatments and conscientious objection.

This document provides a response to those requests, aims to assist professional practitioners to exercise their judgement and reinforces the importance of the Code of Professional Conduct.

B. The Code of Professional Conduct and the subject of accountability

1. This new UKCC advisory document has been produced in order to establish more clearly the extent of accountability of registered nurses, midwives and health visitors and to assist them in the exercise of professional accountability in order to achieve high standards of professional practice.
2. The Code begins with an unequivocal statement **'Each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to justify public trust and confidence, to uphold and enhance the good standing and reputation of the profession, to serve the interests of society, and above all to safeguard the interests of individual patients and clients'**.

This introductory clause indicates that a registered practitioner is accountable for her actions as a professional at all times, whether engaged in current practice or not and whether on or off duty.

In situations where the practitioner is employed she will be accountable to the employer for providing a service which she is employed to provide and for the proper use of the resources made available by the employer for this purpose.

In the circumstances described in the preceding two paragraphs the practitioner has an ultimate accountability to the UKCC for any failure to satisfy the requirements of the introductory paragraph of the Code of Professional Conduct.

The words 'accountable' and 'accountability' each occur only once in the Code, both being found in the stem paragraph out of which the subsequent 14 clauses grow. They do, however, provide its central focus as the Code is built upon the expectation that practitioners will conduct themselves in the manner it describes.

3. Accountability is an integral part of professional practice, since, in the course of that practice, the practitioner has to make judgements in a wide variety of circumstances and be answerable for those judgements. The Code of Professional Conduct does not seek to state all the circumstances in which accountability has to be exercised, but to state important principles.

The primacy of the interests of the public and patient or client provide the first theme of the Code and establish the point that, in determining his or her approach to professional practice, the individual nurse, midwife or health visitor should recognise that the interests of public

and patient must predominate over those of practitioner and profession. The second major theme is the exercise by each practitioner of personal professional accountability in such a manner as to respect the primacy of those interests.

4. The Code of Professional Conduct states unequivocally that all practitioners who are registered on the UKCC's register are required to seek to set and achieve high standards and thereby to honour the requirement of **Clause 1 of the Code** which states that each registered nurse, midwife and health visitor shall:-

1. **'Act always in such a way as to promote and safeguard the wellbeing and interests of patients and clients'**.

It is recognised that, in many situations in which practitioners practice, there may be a tension between the maintenance of standards and the availability or use of resources. It is essential, however, that the profession, both through its regulatory body (the UKCC) and its individual practitioners, adheres to its desire to enhance standards and to achieve high standards rather than to simply accept minimum standards. Practitioners must seek remedies in those situations where factors in the environment obstruct the achievement of high standards: to start from a compromise position and silently to tolerate poor standards is to act in a manner contrary to the interests of patients or clients, and thus renege on personal professional accountability.

C. Concern in respect of the environment of care

1. The dilemma for practitioners in many settings in respect of the environment of care is very real and has been well documented. If practitioners express concern at the situations which obstruct the achievement of satisfactory standards they risk censure from their employers. On the other hand, failure to make concerns known renders practitioners vulnerable to complaint to their regulatory body (the UKCC) for failing to satisfy its standards and places their registration status in jeopardy.

The sections of the Code of Professional Conduct that are particularly relevant to this issue are the introductory paragraphs and clauses numbered 1, 2, 3, 10 & 11. **These parts of the Code apply to each and every person on the Council's register. Whether engaged in direct care of the patient or client, or further removed but in a position to exert influence over the setting in which that contact exists, the practitioner is subject to the Code and has an accountability for her actions or omissions.**

2. The import of the Sections of the Code referred to is that, having, as part of her professional accountability, the responsibility to 'serve the interests of society and above all to safeguard the interests of individual patients and clients' and to 'act always in such a way as to promote and safeguard the wellbeing and interests of patients/clients', the registered nurse, midwife and health visitor must make appropriate representations about the environment of care:-

- (a) where patients or clients seem likely to be placed in jeopardy and/or standards of practice endangered;
- (b) where the staff in such settings are at risk because of the pressure of work and/or inadequacy of resources (which again places patients at risk);
and
- (c) where valuable resources are being used inappropriately.

This is an essential part of the communication process that should operate in any facility providing health care, to ensure that those who determine, manage and allocate resources do so with full knowledge of the consequences for the achievement of satisfactory standards. Nurses, midwives and health visitors in management positions should ensure that all relevant information on standards of practice is obtained and communicated with others involved in health policy and management in the interests of standards and safety.

3. Practitioners engaged in direct patient or client care should not be deterred from making representations of their concerns regarding the environment of care simply because they believe that resources are unavailable or that action will not result. The immediate professional manager to whom such information is given, having assessed that information, should ensure that it is communicated to more senior professional managers. This is important in order that, should complaints be made about the practitioners involved in delivering care, the immediate and senior managers will be able to confirm that the perceived inadequacies in the environment of care have been drawn to their attention.

It is clearly wrong for any practitioner to pretend to be coping with the workload, to delude herself into the conviction that things are better than they really are, to aid and abet the abuse and breakdown of a colleague, or to tolerate in silence any matters in her work setting that place patients at risk, jeopardise standards of practice, or deny patients privacy and dignity.

In summary, Section C of this document simply restates the UKCC's expectations (set out in the Code of Professional Conduct) that while accepting their responsibilities and doing their best to fulfil them, practitioners on its register will ensure that the reality of their clinical environment and practice is made known to and understood by appropriate persons or authorities, doing this as an expression of their personal professional accountability exercised in the public interest. An essential part of this process is the making of contemporaneous and accurate records of the consequences for patients and clients if they have not been given the care they required.

4. **The Code of Professional Conduct applies to all persons on the Council's register irrespective of the post held. Their perspective will vary with their role, but they share the overall responsibility for care. No practitioner will find support in the Code or from the UKCC for the contention that genuinely held concerns should not be expressed or, if expressed, should attract censure.**

D. Consent and truth

1. It is self-evident that for it to have any meaning consent has to be informed. For the purposes of this document "informed consent" means that the practitioner involved explains the intended test or procedure to the patient without bias and in as much detail (including detail of possible reactions, complications, side effects and social or personal ramifications) as the patient requires. In the case of an unquestioning patient the practitioner assesses and determines what information the patient needs so that the patient may make an informed decision. The practitioner should impart the information in a sensitive manner, recognising that it might cause distress. The patient must be given time to consider the information before being required to give the consent unless it is an emergency situation.

2. In many instances the practitioner involved in obtaining informed consent would be a registered medical practitioner. In those circumstances it is the medical practitioner who should impart the information and subsequently seek the signed consent. Normally, in respect of patients in hospital, there are good reasons why the information should be given and the consent sought in the presence of a nurse, midwife or health visitor. Where the procedure or test is to be performed by a nurse, midwife or health visitor the standards described in the preceding paragraph apply to the consent sought.

3. If the nurse, midwife or health visitor does not feel that sufficient information has been given in terms readily understandable to the patient so as to enable him to make a truly informed decision, it is for her to state this opinion and seek to have the situation remedied. The practitioner might decide not to co-operate with a procedure if convinced that the decision to agree to it being performed was not truly informed. Discussion of such matters between the health professionals concerned should not take place in the presence of patients.

In certain situations and with certain client groups the practitioner's level of responsibility in this respect is greatly increased where she stands in "loco parentis" for a patient or client.

4. There are occasions on which, although the patient has been given information by the medical practitioner about an intended procedure for which he has given consent, his subsequent statements and questions to a nurse, midwife or health visitor indicate a failure to understand what is to be done, its risks and its ramifications. Where this proves to be the case it is necessary for that practitioner, in the patient's interest, to recall the relevant medical practitioner so that the deficiencies can be remedied without delay.

The purpose of this approach is to ensure that all professional practitioners involved in the patient's care respect the primacy of that patient's interests, honour their personal professional accountability and avoid the risk of complaint or charges of assault. The practitioner who properly fulfils her responsibilities in this respect should be recognised by medical colleagues as a source of support and information to improve the overall care of the patient.

5. The concept of informed consent and that of truth telling are closely related. If it is to be believed that, on occasions, practitioners withhold information from their patients the damage to public trust and confidence in the profession, on which the introduction to the Code of Professional Conduct places great emphasis, will be enormous.

6. This is yet another area in which judgements have to be made and introduces another facet of the exercise of accountability. If it is accepted that the patient has a right to information about his condition it follows that the professional practitioners involved in his care have a duty to provide such information. Recognition of the patient's condition and the likely effect of the information might lead the professionals to be selective about 'what' and 'when' but the responsibility is on them to provide information. There may be occasions on which, after consultation with the relatives of a patient by the health professionals involved in that patient's care, some information is temporarily withheld. If, however, something less than the whole truth is told at a particular point in time it should never be because the practitioner is unable to cope with the effects of telling the whole truth. Such controlled release of information (i.e. less than the whole truth) should only ever be in the interests of the patient, and the practitioner should be able to justify the action taken.

7. It is recognised that this is an area in which there is the potential for conflict between professionals involved in the care of the same patient or client. The existence of good, trusting relationships between professionals concerned will promote the development of agreed approaches to truth telling. This subject should be discussed between all the professional practitioners involved so that the rights of patients are not affected adversely. This should minimise the number of occasions on which, after a patient or client has been given incomplete information, a nurse, midwife or health visitor is faced with a request for the whole truth. Accountability can never be exercised by ignoring the rights and interests of the patient or client.

E. Advocacy on behalf of patients and clients

1. The introductory paragraphs of the Code of Professional Conduct, together with several of its clauses, indicate clearly the expectation that the practitioner will accept a role as an advocate on behalf of his or her patients/clients. Opinions vary as to what exactly that means. Some tend to want to identify advocacy as a separate and distinct subject. It is not. It is a component of many professional activities of this and other professions. Some of these professional activities are the subject of other sections of this document.

2. **Advocacy is concerned with promoting and safeguarding the wellbeing and interests of patients and clients. It is not concerned with conflict for its own sake.** It is important that this fact is recognised, since some practitioners seem to regard advocacy on behalf of patients or clients as an adversarial activity and feel either attracted to it or not able to accept it for that reason. Dictionaries define an advocate as 'one who pleads the cause of another' or 'one who recommends or urges something' and indicates that advocacy is a positive, constructive activity.

3. There are occasions on which the practitioner's advocacy role has to be exercised to 'plead the cause of another' where, in the case of any person incapable of making informed decisions, the parents or relatives withhold consent for treatment which the various practitioners involved believe to be in the best interests of the patient. The parents or relatives, from their knowledge of the patient, will also have an opinion as to what constitutes his or her best interests. There have been a limited number of cases in which the courts have taken the view that the parents or relatives have not decided in the patient's best interests. Taking the right of decision away from the parents or relatives should only occur in the rarest of cases. The practitioner's advocacy role in situations of this kind requires knowledge of the patient's condition and prognosis, sensitivity to the feelings of the parents or relatives and considerable empathy.

4. **To fulfil the Council's expectations set out in the Code is, therefore, to be the advocate for the patient or client in this sense. Each practitioner must determine exactly how this aspect of personal professional accountability is satisfied within her particular sphere of practice. This requires the exercise of judgement as to the 'when' and 'how'. The practitioner must be sure that it is the interests of the patient or client that are being promoted rather than the patient or client being used as a vehicle for the promotion of personal or sectional professional interests. The Code of**

Professional Conduct envisages the role of patient or client advocate as an integral and essential aspect of good professional practice.

5. Just as the practice of nursing involves the practitioner in assisting the patient with those physical activities which he would do for himself were he able, so too the exercise of professional accountability involves the practitioner in assisting the patient by making such representations on his behalf as he would make himself if he were able.

F. Collaboration and co-operation in care

1. Clause 5 of the Code of Professional Conduct requires that **'Each registered nurse, midwife and health visitor, in the exercise of professional accountability shall work in a collaborative and co-operative manner with other health care professionals and recognise and respect their particular contributions within the health care team'**. This clause deliberately emphasises the importance of collaboration and co-operation and, by implication, the importance of the avoidance of dispute and the promotion of good relationships and a spirit of co-operation and mutual respect within the team.

2. It does so because it is clearly impossible for any one profession or agency to possess all the knowledge, skill and resources to be employed in meeting the total health care needs of society. The delivery of full and appropriate care to patients/clients frequently necessitates the participation of professional practitioners from more than one profession, their efforts often being supplemented by other agencies and persons.

The UKCC recognises the complexity of medical and health care and stresses the need to appreciate the complementary contribution of the professions and others involved.

The delivery of care is therefore often a multi-profession and multi-agency activity which, in order to be effective, must be based on mutual understanding, trust, respect and co-operation.

3. It is self-evident that collaborative and co-operative working is essential if patients and clients are to be provided with the care they need and if it is to be of the quality required. It is worthy of note that this concept of teamwork is evident in many situations in which the care of patients and clients is a shared responsibility. Unfortunately there are exceptions. Experience has demonstrated that such co-operation and collaboration is not always easily achieved if:-

- (a) individual members of the team have their own specific and separate objectives;
- or
- (b) one member of the team seeks to adopt a dominant role to the exclusion of the opinions, knowledge and skill of its other members.

In such circumstances it is important to stress that the interests of the patient or client must remain paramount.

4. The UKCC and the General Medical Council agree that there is a range of issues which calls for co-operation

between the professions at both national and local level and wish to encourage this co-operation.

5. In spite of acceptance of the importance of co-operation and collaboration, differences can sometimes occur within the team regarding appropriate care and treatment. Such conflict can become an influence for good if it results in full discussion between members of the team. It may prove harmful to the care and treatment of patients or clients unless resolved in a manner which recognises the special contribution of each professional group, agency and individual and ensures that the interests and needs of the patient or client remain paramount.

6. **Collaboration and co-operation between health care professionals is also necessary in both research and planning related to the provision or improvement of services.** This may sometimes give rise to concern where one professional group is requested to pass information (obtained by its members in the course of professional practice) to a member of another professional group to use for a purpose other than that for which it was obtained and recorded. That level of concern will inevitably rise unless it can be seen that the purpose for which the information is required is valid, the information is made available only to persons bound by the same standards of confidentiality and the means of storage of that information is secure.

This should not present a problem where consent can be obtained from the patients or clients to whom the information relates or from relatives who have been provided with the relevant information. In certain fields, such as care of the elderly and persons with mental illness and mental handicap, the information gathering and research geared to the provision of services for these client groups may need to proceed without specific consent. This should only occur where the individuals receiving care are unable to give informed consent and where there is no close contact with relatives. Those who proceed without consent in these particular circumstances must be satisfied that their activities will not affect the current provision of care adversely and that the activity is directed to the provision of appropriate or improved services for future recipients of care.

It is anticipated that disputes will be avoided by relevant inter-professional discussions in advance of submissions of the projects for approval by the appropriate ethical committees. Where a dispute does arise it should be resolved between colleagues and the ethical committee.

Clause 9 of the Code of Professional Conduct and the UKCC's Advisory Paper on 'Confidentiality' provide further sources of reference for nurses, midwives and health visitors in respect of this aspect of practice.

G. Objection to participation in care and treatment

1. Clause 7 of the Code of Professional Conduct states:

'Make known to an appropriate person or authority any conscientious objection which may be relevant to professional practice.'

2. The law does not provide a general opportunity for practitioners to register a conscientious objection to participation in care and treatment. That right applies in respect of termination of pregnancy only (not the care of the patient thereafter) under the terms of Section 4 of the Abortion Act 1967.

3. Some practitioners choose not to participate in certain other forms of treatment on the grounds of conscience. Since the law provides no basic right to such a refusal it is imperative that any practitioner should be careful not to accept employment in a post where it is known that a form of treatment to which she has a conscientious objection is regularly used. In circumstances where a practitioner finds that a form of treatment to which she objects, but which is not usually employed, is to be used she must declare that objection with sufficient time for her managers to make alternative staffing arrangements and must not refuse to participate in emergency treatment.

Some practitioners may object to participation in certain forms of treatment, such as resuscitative treatment of the elderly, the transfusion of blood, or electro-convulsive therapy. These practitioners must respect clause 7 of the Code and make their position clear to their professional colleagues and managers, and recognise that this may have implications for their contract of employment.

4. Objection to participation in treatment does not only occur as a product of conscience. It is the Council's stated position that, on each and every occasion a prescribed medication is being administered, the practitioner should ensure that, in her view, the patient is not presenting symptoms that contra-indicate its administration. The practitioner who is concerned about the administration of a particular drug in these circumstances might reasonably ask the prescribing doctor to attend the patient and, if the prescriber still requires it to be given, to request her to administer the medication if not fully reassured. The practitioner involved in such an incident should make a detailed record of the reasons why she felt concern and, if so, why she declined to administer prescribed medication.

5. The principle that applies in the previous paragraph can also be applied in appropriate circumstances to substances that are prescribed for topical use including wound dressings. Where the practitioner attending the

patient believes (from knowledge, published research evidence or from previous experience) that the prescribed substance may be harmful, or even more so where it is evident that it is actively harmful, she should make a record of the condition of the wound or site (where appropriate including a photographic record) and ask the prescribing medical practitioner to attend.

If the prescription stands after medical examination the practitioner, having chosen either to respond to the prescription or not, should make a detailed record of the reasons for her expressed concern and subsequent actions.

It is believed that the spirit of co-operation and mutual respect referred to at paragraph F1. of this document should make such situations exceptional.

6. Objections to participation in treatment are not always associated with the nature or form of treatment or its appropriateness in a particular set of circumstances. Some practitioners indicate their wish or active intention to refuse to participate in the delivery of care to patients with certain conditions. Such refusal may be associated particularly with patients suffering from Hepatitis B Infection and those with Acquired Immune Deficiency Syndrome, AIDS Related Complex or who are HIV sero-positive but asymptomatic.

Those who seek the UKCC's support for such actual or intended refusal are informed that the Code of Professional Conduct does not provide a formula for being selective about the categories of patient or client for whom the practitioner will care. To seek to be so selective is to demonstrate unacceptable conduct. The UKCC expects its practitioners to adopt a non-judgemental approach in the exercise of their caring role.

H. Summary of the principles against which to exercise accountability

1. The interests of the patient or client are paramount.
2. Professional accountability must be exercised in such a manner as to ensure that the primacy of the interests of patients or clients is respected and must not be overridden by those of the professions or their practitioners.
3. The exercise of accountability requires the practitioner to seek to achieve and maintain high standards.
4. Advocacy on behalf of patients or clients is an essential feature of the exercise of accountability by a professional practitioner.
5. The role of other persons in the delivery of health care to patients or clients must be recognised and respected, provided that the first principle above is honoured.
6. Public trust and confidence in the profession is dependent on its practitioners being seen to exercise their accountability responsibly.
7. Each registered nurse, midwife or health visitor must be able to justify any action or decision not to act taken in the course of her professional practice.

'Exercising Accountability' is the fourth in a series to supplement the Code of Professional Conduct (Second Edition; November 1984) and is made available free to all persons on the UKCC's professional register to assist them and to stimulate discussion of this important subject.

It should be read in conjunction with the Code of Professional Conduct for the Nurse, Midwife and Health Visitor and other UKCC Advisory Papers.

The Council, through its professional staff, is always willing to respond to individual requests for advice on matters related to professional practice.

Previous UKCC Advisory Documents in this series are:

- (a) 'Advertising by Registered Nurses, Midwives and Health Visitors' (1985)
- (b) 'Administration of Medicines' (1986)
- (c) 'Confidentiality' (1987)