Chapter 1

Accountability

Learning objectives

- Identify the current plans regarding regulation of healthcare assistants
- Define accountability
- Relate accountability to the healthcare assistants role
- Describe the duty of care and how it relates to negligence
- Discuss the process of obtaining consent
- List the key elements of the Mental Capacity Bill

Aim of this chapter

The aim of this chapter is for healthcare assistants to understand the issues and concept of accountability relating both to their role and to others around them.

This chapter covers accountability and issues surrounding accountability in relation to clinical skills. The role of the healthcare assistant has changed dramatically over the past decade, with healthcare assistants taking on roles traditionally associated with registered nurses, including clinical skills (Hancock and Campbell 2006). The introduction of healthcare assistants has been seen as both a necessary and a vital response to previous resource constraints, and to the declining availability of enrolled, student and registered nursing staff on the wards or in the community, with healthcare assistants providing a valuable alternative (Thornley 2000; McKenna et al. 2004).

Healthcare assistants are employed in a variety of clinical settings and carry out a range of tasks and procedures which has led to the distinction between a nurse and a healthcare assistant becoming blurred (McKenna et al. 2004). However, tasks and procedures are being undertaken without regulation, clear boundaries, or systematic education or training (McKenna et al. 2004). Growth in the number of healthcare assistants has increased dramatically and this group is now the fastest growing occupational group in the NHS (Storey 2007). This provides a valuable contribution in healthcare in relation to clinical skills provision for patients.

Regulatory body

Healthcare assistants can join the RCN if their routine health or social care work is delegated to them by a registered nurse or midwife, or they have a qualification in health and care level one of the National Qualifications Framework in England, Wales and Northern Ireland or level three of the Scottish Credit and Qualifications Framework in Scotland (RCN 2009). The need to regulate healthcare assistants was first raised in *The NHS Plan* (Department of Health [DH] 2000a) and in March 2004 a consultation document was published examining the proposal for

extending regulation of healthcare staff (DH 2004). A benefit to regulation would be closing a current loophole that poses a threat to patient safety. This loophole allows previously registered nurses who have been struck off the Nursing and Midwifery Council (NMC) register (see later) to work as healthcare assistants (Nazarko 1999). This could mean that, in practice, patients could be cared for by a healthcare assistant who has previously been sacked for reasons that could include poor quality patient care. Duffin (2006) reports on a convicted rapist who was struck off the NMC register taking up a post as a care assistant at a nursing home for people with mental illness, and how this brought two main issues to the fore: the fact that there was no register for support workers, and that no one oversaw their conduct.

For registered nurses the NMC is the main focus for regulatory accountability. Other professional groups also have professional bodies, e.g. doctors are accountable to the General Medical Council (GMC).

Reflection point

Identify other professional groups within your clinical area and find out the professional bodies to which they report.

Storey (2007) identifies the following reasons for healthcare assistant role regulation to occur:

- To protect the public
- To protect the individual healthcare assistant
- To provide clarity in defining roles of healthcare assistants and healthcare professionals.

Regulation of healthcare assistants is currently being debated but is likely to happen in the future with the general consensus that they should be regulated, the problem being who should do the regulating (Storey 2007).

In Scotland a short working group looked at regulation of healthcare assistants, and the outcome indicated a model of service-led regulation with the addition of a centralised, mandatory, occupational register (Scottish Executive 2006). This led to a project led by the Scottish Executive (2006) with the aim of securing an appropriate form of regulation for healthcare assistants on the grounds of public protection. A supported pilot has been set up with proposed national standards that link to the strand of Agenda for Change concerning knowledge and skills, which will allow the transfer of knowledge and skills for healthcare assistants across the UK. This would ensure that areas such as the recruitment process and conduct and practice would all have a set standard and therefore promote public safety (Scottish Executive 2006). It would also stop healthcare assistants being recruited into posts without any induction or formal training (Parish 2006). The DH (2006a) are looking to adopt this UK-wide employer-led approach to the regulation of this group based on the outcomes of the project. However, the RCN has concerns that, if the central regulation does not encompass all staff who are responsible, or report to nurses, it will not be comprehensive enough (RCN 2006). The NMC is also anxious that they are involved in both developing and implementing an appropriate model (NMC 2006).

What is evident is that current practices will not remain the same, and the current situation with no healthcare assistant register and no professional body to reside over conduct issues will not continue. Proposals in the future for a single code for any health professional in the UK have been suggested, although arguments about whether this can or should be combined in a single

body are currently being debated (Caulfield 2005). In the interim healthcare assistants can voice their opinions to unions and their employers while waiting on policy-makers to decide on how registration will be implemented (McKenna et al. 2004).

What do we mean by accountability?

Accountability can be defined as being responsible for the outcome of actions and, as a consequence, taking the blame when something goes wrong (Caulfield 2005). Jacobs (2004) reports that accountability is difficult to describe and that nobody is really sure what it means except that the concept is intrinsically linked to professionalism. For qualified nurses, it is being able to justify actions that require a knowledge base on which decisions are made.

The NMC (2008) states that individual nurses, as professionals, must be accountable for their actions and any omissions in practice. Furthermore, they must also be able to justify decisions that are made. The Code (2008) also states that nurses must:

- Make the care of people their first concern, treating them as individuals and respecting their dignity
- Work with others to protect and promote the health and wellbeing of those in their care, their families and carers, and the wider community
- Provide a high standard of practice and care at all times
- Be open and honest, act with integrity and uphold the reputation of their profession.

Areas of accountability and developing roles

Dimond (2004) reports four areas of responsibility relating to registered nurses as shown in Figure 1.1. As mentioned above, healthcare assistants do not have a professional body, and are therefore not accountable to a profession, but they are accountable in the other areas that are shown and discussed.

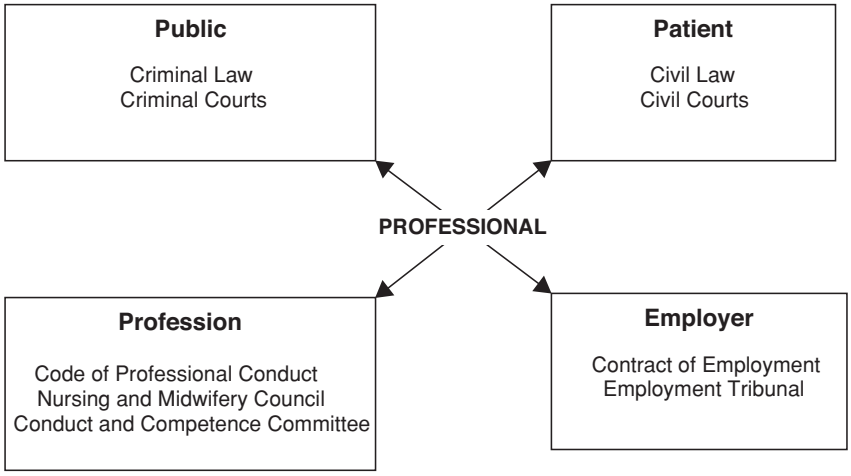

Figure 1.1 Accountability for the registered nurse. (Reproduced from Dimond [2004], with the permission of Pearson.)

Public

Accountability to the public would involve a breach of criminal law and prosecution through the criminal courts (Dimond 2004). An example of this would be if a healthcare assistant caused the death of a patient through their practice. The individual would be prosecuted through the criminal courts for that crime.

Patients

Civil law is actionable in the civil courts and may or may not be a crime (Dimond 2004). Individuals can take out legal proceedings against any healthcare professional, including healthcare assistants. The organisation will take responsibility for this under a concept known as vicarious liability (see later), providing the worker has followed policies and procedures. The law imposes a duty of care (see later) on a practitioner, including healthcare assistants, in circumstances where it is reasonably foreseeable that the practitioner could harm a patient through their action or failure to act (Cox 2006). Healthcare assistants are legally accountable to the patient for any errors that they may make through civil law (RCN 2007). An example here could be if, during cannulation, a healthcare assistant hit a nerve and caused pain, and the patient wished to take legal proceedings.

Employer

The healthcare assistant is accountable to their employer as the contract of employment forms a contractual arrangement and details the employment duties (Caulfield 2005; RCN 2007). It is considered good practice that all employees are given a job description and personal specifications detailing their role and responsibilities (RCN 2007). In relation to healthcare assistants, where the role can be poorly defined and duties therefore misunderstood, the RCN (2007) have suggested that the following guidelines be put in place for primary health care, but the principles are important, and can be related to all areas of practice:

- A clear list of appropriate tasks, with adequate training to enable them to undertake the tasks as necessary
- Clear guidance on role boundaries
- Agreed protocols for the delivery of care
- Clarification of the issues around delegation, accountability, vicarious liability and indemnity insurance (see later)
- Supervision, support and guidance in the role
- Opportunity to develop new roles as practice and patients' needs allow.

It is also recommended that clear lines of responsibility should be identified so it is clear what healthcare assistants are responsible for and to whom. This can be problematic, as Workman (1996) reported, because, if qualified nurses lack clarity in their own role, it has an effect on the role of the healthcare assistant. In addition this can be further complicated in the community setting, because the healthcare assistant and nurse may have different employers making the lines of accountability unclear (Nazarko 1999).

Delegation

Where healthcare assistants who take on tasks that are traditionally those carried out by qualified professionals and are directly given these tasks by qualified staff; these staff remain accountable

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for the appropriateness of the delegation and for ensuring that adequate supervision or support is provided (Tilley and Watson 2004). A failure to supervise can lead to the nurse who delegates being sued for negligence (discussed later) by the worker to whom she has caused harm, or the patient who has suffered harm (Young 1994). Therefore, delegation of duties to healthcare assistants should be delegated in the knowledge that they will be carried out to the quality standard expected by a nurse who would normally undertake the task (Dimond 2004). This requires an understanding of the role of both the qualified nurse and the healthcare assistant (McKenna et al. 2004).

Reflection point

A registered nurse (RN) delegates the task of taking a patient's temperature using a tympanic thermometer (this measures the temperature in the tympanic membrane in the ear). You have never seen the piece of equipment before. What would your response be? Do you think that this is an appropriate task to delegate?

In the document *Supervision, Accountability and Delegation of Activities to Support Workers: A guide for registered practitioners and support workers*, developed by the RCN, together with The Royal College of Speech and Language Therapists, the British Dietetic Association and the Chartered Society of Physiotherapy (RCN et al. 2006), the following guidance is given about delegation:

> Delegation is the process by which a registered practitioner can allocate work to a healthcare assistant who is deemed competent to undertake that task, and the worker then carries the responsibility for that task. Registered practitioners have a legal responsibility to have determined the knowledge and skill level required to perform the delegated task and therefore they are accountable for delegating the task. The healthcare assistant is accountable for accepting the delegated task, as well as being responsible for their actions in carrying it out. There is also a distinction between delegation and assignment. In relation to delegation, the support worker is responsible while the registered practitioner retains accountability whereas with assignment, both the responsibility and accountability for an activity passes from one individual to the other.

It is essential that delegation is appropriate and the principles of delegation adapted from the RCN document (RCN et al. 2006) are shown in Box 1.1.

Reflection point

In relation to these principles, identify and reflect on the tasks that are delegated to you within your own organisation. Seek out any local policies and procedures that are in place to define the tasks that can be undertaken following competency-based training.

Choosing tasks or roles to be undertaken by a healthcare assistant is actually a complex professional activity; it depends on the registered practitioner's professional opinion and, for

Box 1.1 Principles of delegation

- The primary motivation for delegation is to serve the interests of the patient/client, which in turn protects the public.
- The registered practitioner undertakes appropriate assessment, planning, implementation and evaluation of the delegated role.
- The person to whom the task is delegated must have the appropriate role, level of experience and competence to carry it out. This will ensure that the task is appropriate to the individual.
- Registered practitioners must not delegate tasks and responsibilities to colleagues who are outside their level of skill and experience. This will ensure that inappropriate tasks are not delegated.
- The healthcare assistant should undertake training to ensure competency in carrying out any tasks required. This training should be provided by the employer and in some instances will involve supervised practice of the skill before competence is achieved.
- The task to be delegated is discussed and, if both the practitioner and support worker feel confident, the healthcare assistant can then carry out the delegated work/task. This ensures parties are consulted and in agreement.
- The level of supervision and feedback provided is appropriate to the task being delegated. This will be based on the recorded knowledge and competence of the healthcare assistant, the needs of the patient/client, the service setting and the tasks assigned.
- Regular supervision time is agreed and adhered to. This ensures that ongoing support is available.
- In a multiprofessional setting, supervision arrangements will vary and depend on the number of disciplines in the team and the line management structures of the registered practitioners. This is a matter that should be checked locally.
- The organisational structure has well-defined lines of accountability and healthcare assistants are clear about their own accountability. This should be fully discussed and agreed.
- The healthcare assistant shares responsibility for raising any issues in supervision and may initiate discussion or request additional information and/or support. This allows areas of concern to be raised and rectified.
- The healthcare assistant will be expected to make decisions within the context of a set of goals/care plan, which have been negotiated with the patient/client and the healthcare team.
- The healthcare assistant must be aware of the extent of their expertise at all times and seek support from available sources, when appropriate. Where possible, sources of support should be clearly identified with line managers when commencing the role and/or taking on new tasks.
- Documentation is completed by the appropriate person and within employers' protocols and professional standards. This will be different for all organisations and should be checked locally.

any particular task, there are no general rules (RCN 2007). The NMC (2008) state that for a registered nurse to delegate effectively they must:

- Establish that anyone who is delegated a task can carry out those instructions
- Confirm that the outcome of the delegated tasks meets the required standards
- Ensure that everyone to whom they are responsible is supervised and supported.

In addition it is important to consider the competence of the healthcare assistant in relation to the activity to be delegated and this is discussed next.

The established view is that the public are not concerned about what qualifications individuals possess, only that they are properly trained to carry out the tasks that they perform, and therefore they are unlikely to challenge any change in the role of the healthcare assistant (Hancock and Campbell 2006). In the interest of patient safety, absence of a nationally recognised standard for healthcare assistants linked to an educational programme is overdue (DH 2000b; Field and Smith 2003). Where possible this training should be part of a nationally recognised qualification, e.g. National Vocational Qualification (NVQ) or, in Scotland, Scottish Vocational Qualification

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(SVQ). Advantages to this training programme are the potential for a formal recognition of experiential learning, which accredits learning 'on the job' and which many staff may achieve outwith a classroom setting (Thornley 2000). Robertson (2006) suggests that, in theory at least, the potential for training and development for healthcare assistants has never been greater. Local policies and procedures will dictate how clinical skills training and competencies are obtained, and these can be supplementary to those achieved within the NVQ/SVQ framework.

For high-quality educational programmes to function well, it is essential that individuals participating in the delivery of this training should be competent in the skills that they are teaching, and also able to compile accurate records (RCN 2007). The advantages of these qualifications are shown in Box 1.2 (RCN 2007).

Box 1.2 Advantages of qualifications

- Encourages close working relationships between registered and support staff
- Ensures a formal assessment of practical competence across the whole range of support activity undertaken in the workplace
- Provides encouragement for support workers to develop knowledge that underpins the practical aspects of their work
- Allows development of transferable and recognisable knowledge and skills

If defined standards of practice were in place, the RCN (2007) would suggest that this would ensure optimum, safe patient care. However, it is also essential that qualified nurses understand these qualifications and the underpinning principles, to ensure that the limitations of the health-care assistants role are understood (Workman 1996). In specialities such as critical care, there is a feeling that a specialised critical care competency framework would also be beneficial (Ormandy et al. 2004).

Related aspects and terminology

Vicarious liability

This is defined as the liability of an employer for the wrongful acts of an employee committed while in the course of employment. This principle operates to make an employer liable, along with the employee, for any negligence caused by the employee provided that they are operating within the organisation's policies and procedures (Tingle 2004). For example, you have performed venepuncture (the taking or drawing of blood) from a patient, having completed all the appropriate education and competency required by your employer. Unfortunately, the next day the patient has bruising at the site. As you had followed all policies and procedures, should the patient sue, the organisation would take responsibility for your actions.

Indemnity insurance

If a patient sues the employing hospital for negligence due to a nurse or healthcare assistant causing injury, the organisation would cover the nurse under vicarious liability (see above). However, the patient can also decide to sue the nurse or a healthcare assistant as a separate case and, in this instance, indemnity insurance would pay for the nurse's legal costs and the compensation paid to the patient (Caulfield 2005).

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The NMC (2008) recommends that professionals in their role for advising, treating and caring for patients take out indemnity insurance. If there are instances where vicarious liability is not accepted, it is pertinent that adequate indemnity insurance is in place. Where indemnity insurance is not secured, patients will need to be fully informed about this, and how this would impact in the event of a professional negligence claim.

If nurses are part of a trade union indemnity cover is usually part of the membership. In cases where registered nurses are not required to have this in place then nor are healthcare assistants. In most instances healthcare assistants will be covered by vicarious liability but this is an area that may change over the next few years. If healthcare assistants work outside their organisation, then care should be taken over establishing whether the other employer, e.g. nursing agency, provides vicarious liability, or if indemnity insurance is required.

Duty of care and negligence

Where a patient or relative is dissatisfied with the care received from either an organisation or an individual, they can sue for clinical negligence. For this to be successful the claimants (patient/relative) must prove the four elements shown in Box 1.3.

Box 1.3 The four elements required to prove clinical negligence

1. The nurse had a duty to provide care to the patient and to follow an acceptable standard of care
It must be established that a legal duty of care is owed to our neighbours, who can be identified as people who are around us (Tingle 2004). Only those who are directly responsible for giving care owe the patient a duty of care, and the concept of duty of care is central to any case of negligence. Once the responsibility for the care of a patient is assumed, it is also assumed that they are owed a legal duty of care (Cox 2006).

An example would be that you are delegated the task of taking a patient's blood pressure; the patient is then owed a duty of care by the healthcare assistant who has been delegated the task.

2. The nurse failed to adhere to the standard of care and there was a breach in the duty
It is generally accepted that every patient should be entitled to a similar standard of care in relation to a particular healthcare intervention, irrespective of where, when or by whom that care is delivered (Cox 2006).

An example would be knowingly not cleansing the skin (as per local policy) before an invasive procedure, e.g. cannulation.

3. The nurse's failure to adhere to the standard of care caused the patient's injuries
The patient was injured due to a substandard of care. An example would be harming a patient by not adhering to the organisation's policy regarding reuse of lancets for blood glucose measurement.

4. The claimant suffered damages as a result of the negligent actions. The damages may be physical, psychological or financial (Showers 1999)
The final part has to prove that the patient was harmed, and the law defines negligence as failure to exercise the degree of care that a reasonable nurse would exercise under the same or similar circumstances (Showers 1999).

An example of this would be a patient developing nerve damage after a healthcare assistant performed venepuncture (taking blood) due to the lack of knowledge of the healthcare assistant, who had not completed competency-based assessment with regard to this skill.

With the role of the healthcare assistant continually changing, often both the individuals performing the job and their managers can be uncertain or confused about the extent of this duty (Cox 2006). The Department of Health published a document *Modernising Nursing Careers: Setting the direction* (DH 2006b), which talks of specialist and advancing roles for registered nurses. As registered nurses take on these roles, it may well widen the role of the healthcare assistant in response to this change.

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Reasonable care

In the UK, judges, without input from a jury, consider cases of negligence (Martin 2005). To successfully defend a negligence claim, the standard of care required derives from the case of *Bolam v Friern Hospital Management Committee* 1957. This case of negligence was brought against a hospital by a psychiatric patient called John Bolam who was undergoing electrical convulsive therapy (ECT). During treatment, when the patient convulsed, he sustained several pelvic fractures. The patient then sued for negligence as he did not receive a muscle relaxant or did not have any means of restraint in place during the convulsive period, factors that would have reduced the risk of fracture. The fact that these risks had not been explained to the patient was also cited. The judge then stated the following definition of what is reasonable:

> . . . the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent . . . it is sufficient if he exercises the skill of an ordinary man exercising that particular art.
>
> McNair J in *Bolam v Friern Hospital Management Committee* 1957

The doctor was not then found guilty of negligence because he acted in accordance with the practice accepted at the time. This case became the leading reference in medical negligence cases and allowed the courts to accept, without question, a body of professional opinion, as long as that opinion is accepted. Indeed, the court will always take the final decision in negligence cases and, although unusual, this can result in the decision not to apply the Bolam test (Corcoran 2000).

To be successful in proving negligence the claimant must prove a direct link between the breach of the duty of care and the harm that occurred (known as causation); if there is no direct link the action for negligence will not succeed (Martin 2005).

Despite the Bolam test involving medical staff, it is still used in relation to nurses to decide if a professional's actions are reasonable (Ford et al. 2000). A registered nurse professing to have nursing skills must use those skills at an ordinary competent level when exercising the art of nursing. This does not apply to individuals such as healthcare assistants, who do not possess nursing registration and the competent level of skills, and therefore healthcare assistants are not in a position to assess nursing needs, because they have no 'special nursing skills' for this task (Ford et al. 2000).

Consent

When undertaking clinical skills, obtaining valid consent is essential in safeguarding both the healthcare assistant and the patient. Valid consent comprises three main elements (Gates et al. 2004):

1. It is given by a competent person (or their representative)
2. It is given voluntarily
3. It is informed.

Obtaining consent is an opportunity to discuss the procedure fully with the patient and this may involve reassurance and support, especially if the procedure is new to the patient or they have had a previous bad experience. Where possible, choose a quiet environment where you will not be interrupted and give the patient plenty of time to be able to ask questions. Once you

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are happy that the patient fully understands the procedure and any possible complications, this should be documented.

As mentioned above valid consent must be given voluntarily and freely but it must also be without influence or undue pressure to accept or refuse treatment (Lavery 2003). Care should also be taken to ensure that the elements of voluntariness, appropriate information and capacity have been fulfilled, because otherwise even written consent becomes invalid (GMC 2001). Sometimes patients can infer consent, e.g. rolling up a sleeve ready to have blood taken; however, information and consent must still be obtained. In relation to clinical skills, where the procedure is minor, it is acknowledged that verbal consent is usually acceptable (Lavery and Ingram 2005).

The NMC (2008) state that, in gaining consent:

- It must be given before any treatment or care commences.
- If individuals accept or decline treatment and care, their wishes must be respected and supported.
- People have a right to be fully involved in decisions about their care.

Capacity

The role of the qualified nurse in relation to mental capacity is that they must be aware of the current legislation and ensure that people who lack capacity remain at the centre of decision-making and are fully safeguarded (NMC 2008).

In the speciality of learning disability, capacity and competence are viewed as the ability of the person to understand the information given to them and make an informed decision about their care (Gates et al. 2004). For this particular speciality the DH has issued specific guidance entitled *Seeking Consent: Working with people with learning disabilities* (DH 2001), and it is recommended that this should be accessed where necessary.

In Scotland there is an Adults with Incapacity Act (Scotland) 2000 (Scottish Executive 2000) and incapacity can be defined as an adult over the age of 16 incapable of:

- acting or
- making decisions or
- communicating decisions or
- understanding decisions or
- retaining the memory of decisions.

Lack of capacity may occur, with only one of the above applying, with particular reference to mental illness or inability to communicate because of physical disability. It may be the case that you are the first person to notice a loss of capacity in a patient and, in these instances, further advice and help should be sought.

Reflection point

Identify patients in your care with possible disabilities that would reduce their capacity.

If the patient is deemed incapable of giving consent then treatment will be strictly undertaken in relation to the Incapacity Act or the Mental Health (Care and Treatment) (Scotland) Act 2003.

Part 5 of the Adults with Incapacity Act (relating to medical treatment and research) allowing treatment to be given to safeguard or promote the physical and mental health of an adult who is unable to consent.

In England, the Department for Constitutional Affairs published a factsheet in April 2004 that summarises the key principles of the then Mental Incapacity Bill (now renamed the Mental Capacity Bill). The key principles from this are adapted in Box 1.4.

Box 1.4 Key principles of incapacity (adapted from Department for Constitutional Affairs 2004)

- An assumption of capacity: every adult has the right to make their own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- Capacity is decision specific: a new assessment must be taken each time that a decision is to be made and no blanket label of incapacity is allowed.
- Participation in decision-making: everyone should be encouraged and enabled to make decisions with help and support given to allow an expression of choice.
- Individuals must retain the right to make what might be seen as eccentric or unwise decisions.
- All decisions must be in the person's bests interests, giving consideration to what the person would have wanted.
- Decisions made on behalf of someone else should be those that are least restrictive of their basic rights and freedoms.

www.dca.gov.uk/menincap/mcbfactsheet.htm

Summary

In summary, accountability of healthcare assistants is currently evolving with impending registration. This will impact on and control the activity of healthcare assistants, something that would be in keeping with the trend for all other healthcare staff (Johnson et al. 2002). In the interim, and following registration, healthcare assistants should ensure that tasks are clearly defined in their job description. In addition a recognised qualification should be sought such as an NVQ/SVQ to ensure safe practice by competent practitioners.

Case study 1.1

A patient requires blood to be taken. You are asked to perform this task. You have had training and done a couple of supervised practice, but have not yet had your final assessment. You take the blood with no injury to the patient. Would this be acceptable, stating your rationale?

Case study 1.2

Mrs Phillips, a 58 year old, requires an indwelling urinary catheter inserted, but has refused before.

Discuss how you proceed to try to gain her consent. Are there issues about her capacity that you should consider?

✔ Self-assessment

Assessment	Aspects	
Accountability	*Have you considered all aspects of this section?*	**Achieved ✔**
	To whom are you accountable?	
	The different areas of accountability	
	The healthcare assistant role and delegation	
	Vicarious liability	
Patient	*Have you considered all aspects of this section?*	**Achieved ✔**
	Duty of care and negligence	
	Reasonable care	
	Consent	
	Capacity	

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