
Legal and Professional Issues

1

Lorraine Hyde

LEARNING OUTCOMES

The practitioner will be able to:

- Understand key aspects of the legal framework that are relevant to these skills.
- Understand how healthcare organisations operate within this framework, in relation to these skills.
- Consider the professional aspects for these skills.
- Understand the importance of evidence-based practice.

INTRODUCTION

Venepuncture and cannulation are the most commonly performed invasive procedures in the NHS. To perform these procedures well, and to ensure a satisfactory outcome for the patient, requires the practitioner to have relevant and up-to-date knowledge and skill (Dougherty 2008). This chapter focuses on the legal and professional implications for nurses who perform these procedures within their practice setting.

THE LEGAL ASPECT

The nursing profession seeks to deliver high quality care at all times and the role of the nurse has expanded significantly over the past decade. The evolving range of responsibilities can be

complex in nature and are related to the technological and medical advances within the healthcare setting. The nurse's role, whilst offering intellectual stimulation and professional satisfaction, brings with it the potential for increased legal risks (Hyde 2008). Nurses must have a working knowledge of the law and how it applies to their practice in order to be safe and competent practitioners.

Sources of law

The law derives from two main sources. The first is Acts of Parliament and Statutory Instruments (also known as statute law) which are enabled by the powers given to Parliament (Hyde 2008). These statutes, which take precedence over all other laws, include the legislation of the European Community. Laws of the European Community automatically become part of the law in the United Kingdom (Dimond 2005). There are many statutes that apply to nursing, such as the Nurses Midwives and Health Visitors Act 1997, the National Health Service Act 1977 and the Health Act 1999.

The common law (also known as case law) is the second source, which is derived from decisions made by judges in individual cases. Thus, common law operates through a system of precedent. The judge, when considering the facts before him and deciding upon a case, is bound by the decision in law made by judges at an earlier case if it is relevant to the facts before him and if that decision was made by a higher court to that in which he is sitting (Dimond 2005). The established order of precedence means that decisions made in the United Kingdom Supreme Court, the highest court of the land, are binding over all lower courts except itself, but would be subject to relevant precedents established in the European Court of Justice (Dimond 2005).

The legal system is divided into two main branches, criminal and civil law. Criminal law relates to crime and breaches can lead to prosecution, whilst civil law deals with all other cases (Hodgson 2002). Civil law is the branch of law whereby a civil action for negligence in relation to the liability of the nurse would be heard. A patient who has suffered harm as a consequence of inadequate care whilst being treated by the nurse can

claim compensation for a breach of duty of care. It is therefore important that the nurse has an understanding of liability in relation to civil action.

THE PROFESSIONAL ASPECT

Statutory regulation of nurses is the function of the Nursing and Midwifery Council (NMC). The professional register is a means of declaring that a reasonable standard of competence and conduct is expected from those named in it. It is also stating that these are the people to whom the NMC has declared its expectations, given its advice and presented its standards, and to whom it can call to account. The Nursing Midwifery Order 2001 requires the NMC to have specific statutory committees, these are the:

- Screeners and Practice Committees – who consider allegation and establish if the complaint is well founded but who may refer the matter to the other committee for consideration
- Investigating Committee (IC)
- Conduct and Competence Committee (CCC)
- Health Committee (HC).

Integral to the NMC function is to protect the public from persons whose fitness to practise is impaired. Fitness to practise implies the registrant's suitability to be on the register without restrictions. Some of the ways in which fitness to practise may be impaired are by misconduct, lack of competence, physical or mental ill-health or a criminal conviction. The CCC holds hearings in public to encourage transparency and to reflect the NMC's public accountability. The sanctions that are available to the committees include issuing a caution, suspension from the register or removal from the register. As a way of ensuring that practitioners are fit to practise and are able to provide relevant and evidence-based nursing intervention, the NMC provides guidance through its Code, which was updated in April 2008. It states: 'The people in your care must be able to trust you with their health and wellbeing', and it requires the nurse or midwife to:

- make the care of people your first concern, treating them as individuals and respecting their dignity

- work with others to protect and promote the health and well-being of those in your 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 your profession.

NMC (2008) p. 1

ACCOUNTABILITY

The concept of accountability is influenced by issues such as authority and autonomy and is related to the concept of professionalism. Watson (2004) states that 'accountability is the hallmark of a profession' in that training and professional registration is required in order to practise. The nurse has both professional and legal accountability for her practice. Nurses are accountable to:

- the NMC in terms of the code of conduct, and the sanction could be removal from the register
- the patient through civil law, and the sanction could be to be sued by the patient
- the employer through contract of employment/employment tribunal, and sanction could be loss of job
- the public through criminal law/courts, and the sanction could be criminal prosecution (Hyde 2008).

There can be overlap within these areas of accountability. For example, if a nurse witnesses a car accident, legally she is not obliged to stop at the scene and offer assistance; however, professionally she would be expected to. The NMC states that the nurse is 'accountable for the care she delivers in emergency situations'.

Accountability is implicit within any area of practice where the practitioner is delivering care. The NMC defines accountability as 'responsible for something or someone', and to be responsible requires knowledge. Clark (2000) describes accountability as meaning 'the professional takes a decision or action not because someone has told him or her to do so, but because, having weighed up the alternatives and consequences in the light of the best available knowledge, he or she believes it is the

right decision or action to take'. The NMC states that in exercising their professional duty nurses must be able to justify their actions as well as their decisions, which is not possible unless the nurse has the necessary knowledge.

Legal accountability applies to every citizen, and nurses like all other professionals are personally accountable through law for their actions or omissions. Such individual legal accountability is channelled through the criminal and civil law in the courts (Tingle 2004). The NMC 2008 code also emphasises that the nurse 'must act lawfully, whether those laws relate to professional practice or personal life'; thus accountability is continuous.

Litigation within healthcare in the United Kingdom has increased over the years and has huge financial implications for the NHS (Dougherty 2003). During 2006–2007 the NHS Litigation Authority (NHSLA) dealt with 5426 clinical negligence claims which cost £579.3 million. Over 80% of these cases were settled out of court (NHSLA 2008). The challenges of nursing within an increasingly complex healthcare framework, and the many competing priorities, mean that the risk of litigation is always present.

DUTY OF CARE

All nurses owe the patients they care for a duty of care. Liability is likely if that duty has been breached, the breach being a failure to meet the required standard of care. The standard of care required is determined by the Bolam test: '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 exercise the ordinary skill of an ordinary man exercising that particular art' (*Bolam v. Fern Hospital Management Committee* 1957). This standard is well established as is *Bolitho* (1997): 'when challenged, if expert opinion could not withstand logical analysis then the judge has the right to conclude that the body of opinion is not reasonable or responsible' (Foster 2002). Consequently, when justifying clinical decisions or actions the practitioner would be expected to have considered their competencies within a particular situation as well as best practice principles if they were subject to litigation.

For a successful litigation the plaintiff must establish three principles on the balance of probabilities. These are:

- that a duty of care was owed by the defendant to the plaintiff
- that there has been a breach of that duty
- that, as a result of that breach, the plaintiff has suffered harm of a kind recognised in law and which is not too remote.

For example, a litigation claim could be evoked if in the course of her duty, a nurse inserted a peripheral cannula using poor technique which caused the patient an injury.

VICARIOUS LIABILITY

NHS Trusts and other employers have two forms of liability: (1) direct liability, i.e. the Trust itself is at fault; and (2) vicarious or indirect liability, i.e. the Trust is responsible for the faults of others, mainly its employees (Dimond 2005). It is a necessary requirement that the employee was acting within the course of their employment and that they were authorised to perform the procedure. For example, a nurse whilst caring for a patient obtains a blood sample from the patient and during the procedure the patient sustains a nerve injury. If the nurse did not have the necessary training or authorisation to perform the procedure, the patient would be able to claim clinical negligence. It is possible that the employer could seek to recover from the employee any compensation which may be paid out. However, the Department of Health advise against such practice (Dimond 2005).

The changing culture of clinical negligence claims has been reflected in the updated code of conduct. The NMC states that the nurse should have personal indemnity insurance and that if the nurse cannot arrange it then she must declare it to the person for whom she is caring as they need to be aware of that fact due to the potential for a clinical negligence claim. Such a declaration relates to registered nurses and not to non-registered healthcare personnel. Indemnity insurance is provided through professional organisations and trade unions.

RECORD KEEPING

Maintaining accurate records is fundamental to nursing practice and yet it is often overlooked, especially when workload demands are high. However, the NMC describes good record keeping as a 'tool for professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow' (NMC 2009).

Failure to document interventions accurately could have serious consequences. In terms of cannulation, records should demonstrate site selection, number of attempts and any problems encountered during the procedure. The record should be signed and dated with the time of insertion. Furthermore, records should demonstrate the care of the peripheral device as well as the outcome of treatment (Dougherty 2008). The nurse should remember that these records will be used in the event of a negligence claim being brought against her and will serve to protect her if the documentation is detailed and relevant. In the absence of relevant records, nursing practice can be called into question since there is no evidence to prove that the interventions took place. The nurse may also find it difficult to recall details since memory fades with time and recall can be scanty. Opinions may then be made about the nurse's fitness to practise because of failures in documentation, since 'good record keeping is an integral part of nursing and midwifery practice, and is essential for to the provision of safe and effective care' (NMC 2009). Furthermore, the practitioner and employer lose protection against negligence claims in the absence of clear and accurate records. Documents provided as evidence in court would be scrutinised and any failures would compromise the practitioner when they came to give evidence. Consequently, to neglect this area of practice is to open oneself to potential professional and legal complications.

CONSENT TO TREATMENT

The notion of consent is based on the principle of respect for the person and thus on the concept of human rights of life and liberty (Tschudin 2003). Central to the thinking about the

nursing care of the patient is the philosophical concept of autonomy. On the premise that people know what is in their best interest, the ethical principle states that the choices of mature people must be respected and, reflecting this principle, the law insists that consent is, in the vast majority of cases, a prerequisite to the care of the patient (Cox 2001). As a registered nurse it is imperative that consent is obtained before any treatment or care is initiated. For consent to be valid the practitioner must ensure that consent is:

- given by a legally competent person
- given voluntarily
- informed (which includes information about the procedure as well as any known risks related to the intervention) (NMC 2008)

Consent may be given in a variety of ways and the law does not require consent to be given in a particular way. Implied, verbal, written and expressed consent are all equally valid; however, they can vary in their value as evidence in proving that consent was given (Dimond 2005). Examples of consent are: (1) a nurse is about to obtain a blood pressure reading and the patient holds out their arm for the procedure, then the consent is implied; (2) the nurse asks the patient if she can obtain a blood sample and the patient agrees, then the consent is verbal; (3) the nurse, prior to insertion of a central venous access device and following a comprehensive explanation of the procedure, asks the patient to sign a written document to confirm consent to the procedure.

Giving full explanations of what is being done, and why, how and when, is essential for the patient to remain a free agent and exercise the right to say no (Tschudin 2003). It is often difficult for nurses to accept a patient's refusal to give consent. However, an action of battery may be brought if treatment is given in the face of an explicit refusal of consent (McHale 2001).

EVIDENCE-BASED PRACTICE

The radical modernisation of the healthcare system that culminated in the publication of the NHS Plan (Department of Health 2000) empowered nurses to undertake a wide range of complex

clinical skills which were traditionally the remit of the medical profession. The nursing profession has embraced the role expansion. However, the role expansion is inextricably linked with the risk of professional and legal complications for the nurse. The procedure of venepuncture and cannulation is commonly practised by nurses (Dougherty 2008). The importance of being competent to perform these procedures must never be underestimated since the consequences of bad technique and lack of knowledge can be serious. Skill is required to learn techniques and use equipment but of equal importance is the knowledge that is required to apply evidence-based practice, assess the patient, problem-solve, manage complications. A good knowledge of equipment is necessary to protect the practitioner from risks such as sharps injury, and agencies such as the National Patient Safety Agency (2007) advocate the use of needle-free systems whenever possible.

The NMC code (NMC 2008) states that each nurse must ensure that their practice is up to date; the notion of lifelong learning is inherent in the code and nurses are encouraged to actively seek out and comply with training programmes which will help inform their professional practice. Failure to maintain knowledge would be viewed as a breach of the code since the NMC emphasises the importance of maintaining competency in order to deliver safe and effective nursing care.

There is currently no national agreed training programme for venepuncture or cannulation; however, the RCN (2010) have published the third edition of their *Standards for Infusion Therapy*, which is essential reading for nurses performing venepuncture and cannulation. There is a risk in assumptions being made about the fact that such procedures, being commonplace, are easy to perform and require minimal knowledge. The reality is that in order for the nurse to deliver safe and effective care and to be competent to work without supervision she must demonstrate that she has maintained her knowledge and skill (NMC 2008).

It has become common practice for organisations to allow non-registered staff to perform cannulation and venepuncture following a period of training. If the procedure is being performed under the delegation of the registered nurse then she

must be satisfied that the delegation is appropriate and be aware of the outcomes of the delegation. The nurse or midwife must:

- establish that anyone they delegate to is able to carry out their instructions
- confirm that the outcome of any delegated task meets the requires standards
- make sure that everyone they are responsible for is supervised and supported NMC (2008).

Clearly, the nurse is ultimately accountable for her actions as well as decisions.

CONCLUSION

The dynamic nature of healthcare makes it essential for nurses to keep up to date with advances in clinical practice to ensure they are fit for purpose. To ensure safe, effective and professional practice requires the nurse to maintain a good knowledge of the professional and legal requirements which influence the delivery of care.

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