CHAPTER 1

Accountability

LEARNING OBJECTIVES

• Identify the current plans regarding regulation of healthcare assistants and assistant practitioners
• Define accountability
• Relate accountability to the healthcare assistant and assistant practitioner role
• Describe the duty of care and how it relates to negligence
• Discuss consent
• List the key elements of the Mental Capacity Act

Aim of this chapter

The aim of this chapter is to enable healthcare assistants and assistant practitioners 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. Healthcare assistants, healthcare support workers and assistant practitioners form an integral part of the contemporary flexible ‘nursing family’ (RCN 2004). A substantial proportion of essential nursing care is now delivered by the unregistered branch of the nursing family with some personnel such as assistant practitioners undertaking work previously performed by registered staff (RCN 2012). Registration and regulation of healthcare assistants, health support workers and assistant practitioners continues to be debated (Vaughan et al. 2014)

Regulation and registration

Registration refers to the process by which professionals such as nurses are registered with a regulatory body. Registered staff are professionally accountable
to their respective regulatory bodies, for example nurses are accountable to the Nursing Midwifery Council (NMC) and allied health professionals to the Health and Care Professions Council (HCPC). Regulation refers to a set of rules that members are required to follow by law (Law Commission et al. 2012: 68): for example, nurses are regulated by the NMC and legally have to follow the rules set out by that specific body; for nurses, therefore, the NMC is the main focus for regulatory accountability (NMC 2015b). The Nursing Midwifery Council regulates nurses and midwives in England, Wales, Scotland and Northern Ireland and exists to protect the public. They set standards of education, training, conduct and performance so that nurses and midwives can deliver high-quality healthcare throughout their careers. The NMC makes sure that nurses and midwives keep their skills and knowledge up to date and uphold a set of professional standards. There is a clear and transparent processes used to investigate nurses and midwives who fall short of those standards. In the event of a serious error, professional misconduct, failure to respect professional boundaries or unethical conduct, a registered nurse is held accountable and can be removed from the register. The NMC hold a register of nurses and midwives allowed to practise in the UK (NMC 2015b).

**Healthcare assistants and assistant practitioners**

Both assistant practitioners and healthcare assistants remain unregistered and without a regulatory body, unlike registered nurses. They do, however, have codes of conduct and it is imperative practitioners become familiar with them.

In Scotland, since 2011 all new HCAs have been required to meet induction standards and comply with a code of conduct, while employers are required to sign up to a code of practice (Scottish Government 2010). In Wales there is an All Wales Code of Conduct for healthcare support workers (Welsh Assembly Government 2011). In addition, the Hywel Dda Health Board introduced a code of conduct for healthcare support workers, along with an employers’ code of practice ‘to provide an assurance framework for public protection’ (Horner 2012; Hywel Dda Health Board 2015). A voluntary register, but no mandatory regulatory system, exists in Northern Ireland. In England, the Coalition Government rejected the recommendation made in Robert Francis’s report into the failings at the Mid Staffordshire Foundation Trust (Francis 2013), that recommended all healthcare support workers should be regulated. Instead Camilla Cavendish (DH 2013b) was asked by the Secretary of State to review and make recommendations on the recruitment, learning and development, management and support of healthcare assistants and social care support workers. The resulting report, published in July 2013, found that the preparation of healthcare assistants and social care support workers for their roles within care settings was inconsistent, and one of the recommendations was the development of the Care Certificate.
In the absence of registration and a regulatory body, all unregistered health and social care workers are recommended to read the chapters of this book and consider them alongside and in addition to the Care Certificate. Local codes have also been developed, please become familiar with your local policy and code(s)

Skills for Health and Skills for Care published the Code of Conduct (2013) for healthcare support workers and adult social care workers. Although this code is voluntary it is seen as best practice. This Code of Conduct sets the standard of conduct expected of healthcare support workers and adult social care workers, outlining the behaviour and attitudes that are expected of those working in health and social care settings to provide safe, compassionate care and support (Skills for Health and Skills for Care 2013).

The role of the assistant practitioner operates at band 4 or above and has emerged since it was first introduced in the Northwest of England in 2002 to cover a number of professions and settings. This role was introduced in the UK to complement the work of registered professionals, working across professional boundaries, and now performs many tasks previously undertaken by registered staff (Vaughan et al. 2014). Skills for Health (2009: 1) defined the role of the Assistant Practitioner as:

An Assistant Practitioner is a worker who competently delivers health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. The Assistant Practitioner would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals. The Assistant Practitioner may transcend professional boundaries. They are accountable to themselves, their employer, and, more importantly, the people they serve.

**THINK ABOUT IT**

Identify other professional groups within your clinical area and find out about the professional bodies to which they report. What are your thoughts about registration? What advantages do you think are attached to registration and are there any negatives?

**Responsibilities and accountability**

Accountability and responsibility are words that are often used interchangeably by health professionals as though they have the same meaning (Griffith 2015). Responsibility means *having control or authority over someone or something* (Griffith and Tenegnah 2010). Carvallo et al. (2012) identify responsibility as accepting a task or duty that you have been given and accepting that task willingly. So it can be seen that responsibilities are linked to your role, which means you require training and assessment of the necessary knowledge, skills, values and ability to undertake a particular task or duty. In order to be responsible, Dimond (2011)
asserts it is also necessary to have legal knowledge, as ignorance of the law is no defence. So as an HCA or AP you are responsible for your practice and for ensuring the interventions undertaken are in the best interests of your patients. Responsibility equates to the duty of care in law. Scrivener et al. (2011) explain that the duty of care applies whether the task involves bathing a patient or complex surgery – in each case there is the opportunity for harm to occur. In this context, the question that arises concerns the standard of care expected of practitioners performing these tasks. This is the legal liability the practitioner owes to the patient. By accepting the responsibility to perform a task the practitioner must ensure the task is performed competently, at least to the standard of the ordinarily competent practitioner in that type of task.

**Accountability**

Accountability is crucial to the protection of the public and individual patients and is a complex concept to understand (Griffith and Tengnah 2010). Nurses are bound by the NMC to be accountable (NMC 2015a). Dimond (2011) reports four arenas of accountability relating to registered nurses:

1. Accountable to the Public via criminal law and criminal courts.
2. Accountable to the Patients via civil law, civil courts.
3. Accountable to the Employer via contract of employment, employment tribunal.
4. Accountable to the Profession via NMC, Conduct and Competence Committee.

Mullen (2014) points out that HCAs and APs are not accountable to a professional body, but they are accountable to the other arenas. Additionally there are also general responsibilities related to accountability laid out for all staff in the NHS Constitution (see Boxes 1.1 and 1.2 for a summary of responsibilities relating to accountability (Mullen 2014)). Put quite simply, Griffith and Tengnah (2010) define accountability as ‘being answerable for your personal acts or omissions to a higher authority with whom you have a legal relationship’.

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**Box 1.1 Accountability**

Code of Conduct for Healthcare Support Workers and Adult Social Care Workers
(Skills for Health and Skills for Care 2013)

**Guidance statements**

As a healthcare support worker or adult social care worker in England, you must:

- Be honest with yourself and others about what you can do, recognise your abilities and the limitations of your competence and only carry out or delegate those tasks agreed in your job description.
- Always behave and present yourself in a way that does not call into question your suitability to work in a health and social care environment.
• Be able to justify and be accountable for your actions or your omissions – what you fail to do.
• Always ask your supervisor or employer about any issues that might affect your ability to do your job competently and safety. If you do not feel competent to carry out an activity, you must report this.
• Comply with your employers agreed ways of working.
• Report any actions or omissions by yourself or colleagues that you feel may compromise the safety or care of people who use healthy and care services and, if necessary, use whistle blowing procedures to report any suspected wrongdoing experiences, activities and people across the NHS.

Box 1.2 NHS Constitution staff responsibilities

A summary of the areas related to accountability
• You have a duty to accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.
• You have a duty to act in accordance with the express and implied terms of your contract of employment.
• You have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.
• You have a duty to protect the confidentiality of personal information that you hold.
• You have a duty to be honest and truthful in applying for a job and in carrying out that job.

Remember: you are still 100% accountable for your acts and omissions.

Areas of accountability

Public
Accountability to the public would involve a breach of criminal law and prosecution through the criminal courts (Dimond 2011). An example of this would be if an HCA or AP 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 2011). Individuals can take out legal proceedings against any healthcare professional, including healthcare assistants and assistant practitioners. The organisation will take responsibility for this under a concept known as vicarious liability that will be discussed later, providing the worker has followed policies and procedures. The law imposes a duty of care on a practitioner in circumstances where it is reasonably foreseeable that the practitioner could harm a patient through their action or failure to act (Cox 2010). Healthcare assistants are legally accountable to the patient for any errors that they may make through civil law (RCN 2011).
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**

Mullen (2014) points out that HCAs and APs are accountable to their employer and as such are expected to follow their contract of duty, to work within the domain of their job description and to follow the codes of responsibility and behaviour, as laid out in the recent code of conduct for healthcare workers (Skills for Health and Skills for Care 2013) (Box 1.1). It is vital, therefore, that you have an up-to-date copy of your job description and that you are competent and trained to undertake the tasks, behaviours and responsibilities described (Mullen 2014). The need for job/role clarification is essential as employers need to ensure the right processes are in place and staff are trained with the right skills (Vaughan et al. 2014)

**Delegation**

The Oxford English Dictionary (2012) defines delegation as, ‘entrusting a task to another person’. HCAs and APs may be delegated or allocated tasks by another member of staff (usually, but not always from a registered practitioner) or they may delegate a task to somebody else (i.e. they are the delegator) (Mullen 2014). The RCN (2011) states:

> If a practitioner such as a registered nurse should delegate a task, then that practitioner must be sure that the delegation is appropriate. This means that the task must be necessary; and the person performing the delegated task, for example a HCA or nursing student, must understand the task and how it is performed, have the skills and abilities to perform the task competently and accept responsibility for carrying it out.

Delegation must always be appropriate and in the best interest of the patient. Simply put, if you are delegated a task, you must have been trained and assessed as competent to undertake that job. If this is not the case, you must inform the person delegating the task to you. Equally, if you are delegating a task to somebody else you must ensure they are competent to perform that task. It is essential that delegation is appropriate, and the principles of delegation adapted from the RCN document (RCN 2011) are shown in Box 1.3.

**THINK ABOUT IT**

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?
Box 1.3 Principles of delegation

- Delegation must always be in the best interest of the patient and not performed simply in an effort to save time or money
- The support worker must have been suitably trained to perform the task
- The support worker should always keep full records of training given, including dates
- There should be written evidence of competence assessment, preferably against recognised standards such as National Occupational Standards
- There should be clear guidelines and protocols in place so that the support worker is not required to make a clinical judgement that they are not competent to make
- The role should be within the support worker’s job description
- The team and any support staff need to be informed that the task has been delegated (e.g. a receptionist in a GP surgery or ward clerk in a hospital setting)
- The person who delegates the task must ensure that an appropriate level of supervision is available and that the support worker has the opportunity for mentorship. The level of supervision and feedback provided must be appropriate to the task being delegated. This will be based on the recorded knowledge and competence of the support worker, the needs of the patient/client, the service setting and the tasks assigned (RCN et al. 2006)
- Ongoing development to ensure that competency is maintained is essential
- The whole process must be assessed for the degree of risk.

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 are accountable for ensuring you have the knowledge and skill level required to perform the delegated task. The healthcare assistant is accountable for accepting the delegated task, as well as being responsible for their actions in carrying it out.

THINK ABOUT IT

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 any particular task, there are no general rules (RCN 2011). The NHS Constitution (Department of Health (DH) 2013), however, applies to registered practitioners who are additionally accountable to their regulatory body for ensuring that the standards of practice, patient care and treatment meet the regulator’s standards. The concept of delegation is included within all professional bodies’ codes of conduct that the registered practitioner is required to follow (Mullen 2014). For example: Standard 11 of The Code, (NMC 2015a) requires nurses to:
Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

1.1 only delegate tasks and duties that are within the other person’s scope of competence, making sure that they fully understand your instructions
1.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care, and
1.3 confirm that the outcome of any tasks you have delegated to someone meets the required standard.

There are a number of aspects to consider in conjunction with the competence of the healthcare assistant and assistant practitioner in relation to the activity to be delegated.

**Related aspects and terminology**

**Competence**

Skills for Health develop National Occupational Standards (NOS) to set clear standards for a wide range of activities for healthcare workers. NOS describe the skills, knowledge and understanding needed to undertake a particular task or job to a nationally recognised level of competence. They cover key activities undertaken within the occupation in question under all the circumstances that the job holder is likely to encounter. HCAs and APs must develop the competencies required within their role to a given standard. The introduction of the Care Certificate has already been discussed and is available from SFH’s website http://www.skillsforcare.org.uk/Standards/Care-Certificate/Care-Certificate.asp.

**Vicarious liability**

Vicarious liability means that the employer is accountable for the standard of care delivered and is responsible for employees working within agreed limits of competence appropriate to the abilities of that employee. Therefore, to remain covered by an employer’s vicarious liability clause, the HCA or AP must only work within this area of assessed competence and within the responsibilities of their role and job description. 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 (Samanta and Samanta 2011). 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**

Where employers are vicariously liable for the actions of their staff, they need to have insurance to cover the risks of clinical negligence claims arising from employee carelessness. Individual practitioners remain legally accountable for their actions but it is rare for injured patients to sue them rather than their employers (Cox 2010).

The Health Care and Associated Professions (Indemnity Arrangements) Order 2014 No. 1887 (2014) states ‘each practising registrant must have in force in relation to that registrant an indemnity arrangement which provides appropriate cover for practising as such’. The NMC Code (2015) standard 12 reflected these new arrangements stating that registered nurses must:

‘12.1 make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice.’

This means, 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 healthcare assistant as a separate case and, in this instance, indemnity insurance would pay for the practitioner’s legal costs and the compensation paid to the patient. While this currently refers to regulated healthcare professionals, there is discussion as to whether HCAs, APs and other support workers will also require mandatory indemnity insurance. Some union membership includes indemnity insurance; it is advisable that you check whether you are currently covered.

**Duty of care and negligence**

The term ‘duty of care’ is used to describe the obligations implicit in the roles of all health or social care workers and is not something that can be opted out of (Mullen 2014). The RCN (2011) guidance highlights the importance of ‘duty of care’, a term that is described clearly: ‘The law imposes a duty of care on practitioners, whether they are HCAs, APs, students, registered nurses, doctors or others, when it is “reasonably foreseeable” that they might cause harm to patients through their actions or their failure to act’ (Cox 2010; RCN 2011). Where a patient or relative is dissatisfied with the care received from either an organisation or an individual, they can sue for clinical negligence. So, HCAs and APs have a duty of care and therefore a legal liability with regard to the patient. Mullen (2014) clearly identifies that HCAs and APs are responsible for:

- Always making the care and safety of patients your first concern.
- Ensuring that the task is necessary and in the patient’s best interest.
- Ensuring your level of practice is of the standard that is expected of your role and the tasks that you perform.
- Keeping your practice and knowledge up to date.
- Always respecting the public, the patients, the clients, carers, NHS staff and partners in other organisations.
• Demonstrating your commitment to team working by cooperating with your colleagues in the NHS and in the wider community.
• Reporting to the registered professional members of the team any concerns, changes, and developments about the patients/clients.
• If you as an HCA or AP supervise the work of other junior members of the team, you need to be sure that what you ask them to do is within their capability and that you are accessible and supportive.
• If you supervise the work of other junior members of the team, that you report any concerns about their performance to your line manager.

Reasonable care
Reasonable care is the level of care which an ordinary and reasonable person would use under comparable circumstances. In the law, it is used as a standard to assess liability. If it can be demonstrated that someone had a duty of care and failed to exercise reasonable care, that person can be held negligent and may be liable for damages. On the other hand, if someone exhibited reasonable care and something happened anyway, this person would not be considered negligent.

Standards of care
The law imposes a duty of care on practitioners, whether healthcare support workers, registered nurses, doctors or Allied Health Professionals (AHPs), in circumstances where it is ‘reasonably foreseeable’ that they might cause harm to the patients through their actions or their failure to act (Cox 2010). This applies whether a complex task is being performed or whether the HCA or AP is bathing a patient and injure a patient through a careless act. The law imposes a standard of care in relation to each task and this standard applies no matter where patients receive treatment and is irrespective of the carer’s qualifications. The legal standard of care is judged by that of the ordinarily competent practitioner performing the particular task or role. Should practitioners fall below this standard of care, they breach their duty of care.

Consent
In 2009, the Department of Health published the second edition of the Reference Guide to Consent for Examination or Treatment (the guide is currently under review, 2015). The Guide describes the process of seeking consent, the importance of establishing whether the person has capacity to give consent, what constitutes valid consent, the form that consent might take and the duration of that consent. It highlights the need to ensure that the consent is given voluntarily and that sufficient information has been imparted to allow valid consent to be made (DH 2009).

The Guide (DH 2009) further identifies that it is a general legal and ethical principle that valid consent must be obtained before starting any treatment,
physical investigation, or providing personal care, for a person. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice. A healthcare professional (or other healthcare staff) who does not respect this principle may be liable both to legal action by the patient and to action by their professional body. Employing bodies may also be liable for the actions of their staff.

Consent is clearly enshrined within the various codes of conduct so that you are working in partnership with patients at all times and that agreement is clearly documented within patient records. For the nursing family, obtaining consent is an opportunity to deliver care, using good communication and interpersonal skills to discuss the procedure fully with the patient, which may involve reassurance and support especially if the procedure is new to the patient, they are anxious 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 are happy that the patient fully understands the procedure and any possible complications, this should be documented. It is important to remember that the patient may refuse to consent: this is their right which must be respected.

There are a number of legal cases that are identified within the Guide (DH 2009) that are worth reading to gain an understanding of the importance and consequences of gaining consent.

**Capacity**

Capacity means the ability to use and understand information to make a decision, and communicate any decision made. Taylor (2013) points out that it is generally presumed in law that adult patients have the capacity to make decisions, unless there is evidence that they do not (Parliament 2005). A decision made by a patient with capacity must be respected, even if it appears unwise or irrational. A patient may want to sign their own discharge; while not logical to us, this patient may have other priorities such as drug or alcohol misuse or they may want to make some arrangements before being admitted from the Accident and Emergency Department. Although hospitals and other healthcare providers have a legal obligation to provide adequate care for their patients (Cassidy v Ministry of Health, 1951), patients do not generally have to accept any offer of treatment.

It can be very frustrating to respect the patients’ rights to autonomy, and healthcare practitioners can feel frustrated by what they see as a foolish or reckless decision. They may also feel uncomfortable knowing that a failure to provide care may lead to liability in civil law (negligence) or a criminal charge of gross negligence manslaughter if the patient dies as a result (R v Adomako, 1994). Ethical awareness and an earnest desire to deliver care in the best interest of the patient can cause healthcare workers to worry about the implications of following a patient’s wishes, particularly if the patient has refused potentially life-saving
treatment. There is always the worry of what might happen to the patient and of potential legal reprisals.

Capacity must be assessed by the health professional who is seeking consent. The issues to be set decided by any assessment are set out in s. 3(1) Mental Capacity Act 2005. These are whether or not the patient is able to:

(a) understand the information relevant to the decision,
(b) retain that information,
(c) weigh that information as part of the process of making the decision, or
(d) communicate his decision (Gallagher et al. 2012).

Where there is cause to question a patient’s decision-making capacity, it can be difficult to decide the best course of action if they refuse treatment. In these situations, cases can be referred for a court declaration on the lawfulness of a proposed course of action (Taylor 2013).

**Mental Capacity Act (2005)**

The law applies to adults over the age of 16 years in England and Wales and is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. Examples of people who may lack capacity include those with:

- dementia;
- a severe learning disability;
- a brain injury;
- a mental health condition;
- a stroke;
- unconsciousness caused by an anaesthetic or sudden accident.

If a person has one of the above conditions it does not necessarily mean they lack the capacity to make a specific decision. Someone can lack capacity to make some decisions (for example, to decide on complex financial issues) but still have the capacity to make other decisions (for example, whether they want or need paracetamol for a headache). The person who would normally assess capacity is the person who would implement the decision if the person had capacity and agreed. For example, a surgeon would assess an individual’s capacity with regards to surgery.

The HCA and AP need to have an understanding of what mental capacity is and recognise that these are potentially vulnerable people, ensuring they are fully safeguarded and remain at the centre of decision-making. Please check your local policy and if you have any uncertainties discuss this with your manager. The RCN (2013) in their document Making it Work: Shared Decision-making and People with Learning Disabilities discuss shared decision-making, which is a process by which people with learning disabilities, their families, carers and healthcare professionals work in partnership to decide on tests, treatments, management or support packages, based on clinical evidence and the person’s
informed choices. This process will very often involve the person’s family, supporters and those closest to the person with a learning disability; the aim is to reach an agreement on the best course of action while at the same time acting in the person’s best interests. The RCN emphasise the work of Coulter and Ellins (2011: 11) that:

The most important reason for practising shared decision-making is that it is the right thing to do. Communication of unbiased and understandable information on treatment or self-management support options, benefits, harms, and uncertainties is an ethical imperative and failure to provide this should be taken as evidence of poor quality care.

**Scotland**

The Adults with Incapacity (Scotland) Act 2000 permits intervention in the affairs of an adult only if:

The person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult and that such benefit cannot reasonably be achieved without the intervention. (s.1(2))

The term adult means a person who has attained the age of 16 years (s.1 (6))

Gallagher et al. (2012) point out the important difference between the Scottish Act and the Act governing England and Wales is the purpose of any intervention – it will ‘benefit’ the person in Scotland and be in their ‘best interests’ in England and Wales. Both Acts and relevant Codes of Practice set out similar matters to be taken into account in assessing capacity and in deciding benefit/best interest.

Lack of capacity may occur, 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.

**THINK ABOUT IT**

Identify patients in your care with possible disabilities that might reduce their capacity. What do you think you can do and what policies should you be aware of?

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) allows 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 best 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**

The need for healthcare assistants and assistant practitioners to gain an understanding of accountability and related issues cannot be over-emphasised. It is vital to have an up-to-date copy of a job description, to ensure they have the education and training required to safely and competently deliver care. While healthcare providers have a responsibility to offer the best care possible, it is important to remember that patients have the right to refuse it.

**CASE STUDY 1.1**

A patient requires a specimen of blood to be taken. You are asked to perform this task. You have had training and done a couple of supervised practices, 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

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### References


