Chapter 1
The Nature of Nursing

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Learning opportunities

This chapter will help you to:

1. Understand the key functions of the Nursing and Midwifery Council
2. Define key roles associated with nurses as they progress from newly qualified staff nurses to modern matrons
3. Begin to appreciate the importance of professional regulation
4. Describe key themes associated with ‘fitness to practise’
5. Understand terminology associated with the phrase ‘Agenda for Change’
6. Discuss the importance of the Knowledge and Skills Framework

Pre-chapter quiz

1. The Nursing and Midwifery Council has five key functions. What are they?
2. Define ‘fitness to practise’
3. What is the role of a health care assistant?
4. Describe the usual nursing hierarchy for a ward
5. Why is confidentiality important?
6. What does the acronym KSF stand for?
7. What is the significance of the Bolam test?
8. What is the definition of ‘reasonable care’?
9. To whom is the nurse accountable?
10. Describe the difference between responsibility and accountability

Introduction

The central role of a nurse is to deliver high-quality, appropriate care to patients within a variety of care settings. The role of a nurse is dynamic; it is continually evolving in all aspects of health care. This chapter will introduce the reader to the role of the Nursing and Midwifery Council (NMC) and the impact of current UK government policies upon
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the delivery of clinical care within the community, hospitals and the independent sector. It will also outline the hierarchical structure often associated with nursing and the roles and responsibilities of specific nursing posts.

‘The National Health Service is not just a great institution but a unique and very British expression of an ideal that health care is not a privilege to be purchased but a moral right secured for all’ (Department of Health [DH], 2008a).

The Nursing and Midwifery Council

The NMC was established in 2002. It has taken over the responsibility for professional regulation of nurses, midwives and health visitors from the United Kingdom Central Council (UKCC) and the associated four national boards that had been established in 1979.

The NMC’s function is that of a regulatory body. The NMC sets standards of conduct and performance (NMC, 2008a); it also maintains a live register of qualified nurses and midwives.

The NMC acts as a resource available to registered and non-registered nurses, their employers and the general public, offering advice and guidance on matters pertaining to nursing practice, such as delegation, advocacy and autonomy (NMC, 2008b). In addition to the above, the NMC provides advice and guidance on professional standards and considers allegations relating to an individual’s fitness to practise, which could be a result of lack of competency, professional misconduct or illness.

Registration and professional accountability

The NMC validates programmes of study provided by schools of nursing and departments of nurse education throughout the UK. With regard to pre-registration nursing, the aim is to ensure that the theoretical and practical components of a programme fulfil set criteria for the admission of graduates to the professional register. The NMC’s representatives periodically visit clinical care areas to which student nurses are allocated in order to ensure that the learning experience is appropriate and meaningful and that practice assessors and mentors adequately support student nurses within the clinical care environments (NMC, 2006a).

Following the completion of a period of undergraduate study, such as Diploma of Higher Education in Nursing, the higher education institution formally notifies the NMC that an individual has followed a recognised undergraduate programme of study and is thus eligible to register as a registered nurse. The higher education institution and the registrant complete and sign a declaration that the registrant is of good health and good character. Students who have commenced their pre-registration education after September 2007 are allocated a sign-off mentor for their final clinical placement (NMC, 2006b). The sign-off mentor, who has met additional criteria, must make the final assessment of practice and confirm to the NMC that the required proficiencies for entry to the register have been achieved.
Standards of conduct and performance

The Code (NMC, 2008a) states that the ‘people in your care must be able to trust you with their health and well being’. To justify that trust, you, the nurse, must:

- 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

As a registered nurse you are individually accountable for actions and omissions when practising and must always be able to justify your decisions. Furthermore, you must always act lawfully, whether those laws relate to your professional practice or personal life. If a registered nurse fails to comply with the tenets of the code, it may bring his or her fitness to practise into question and endanger his or her registration.

Maintenance of a register of nurses and midwives

Another key function (defined in law) is to maintain the professional register. The register is central with respect to the NMC’s function in safeguarding the health and well-being of the public (NMC, 2008c).

There is a mandatory requirement that all nurses re-register every 3 years and pay an annual subscription to the NMC. The standards stipulate that all registered practitioners who wish to remain active on the NMC register must have worked as a nurse or midwife for a minimum of 450 hours in the previous 3 years and undertaken a minimum of 35 hours of learning, which is relevant to the nurse’s or midwife’s area of practice. If the NMC requests to see evidence that the above standards have been met, then the nurse or midwife is required to provide proof that continuing professional development has been undertaken and recorded in their personal portfolio. A continuing professional development portfolio may include the following:

- **Details of your workplace**: Here this could include, for example, Band 5 staff nurse working within an adult intensive care unit
- **Your employer’s details**: Details about your place of employment, for example NHS Trust, private hospital; you may wish to include the number of hours that you are contracted to work, if appropriate
- **Your role**: For example, what your role entails and to whom you are responsible. You may find it useful to look at your job description
- **Evidence of professional learning**: Study days such as moving and handling and cardiopulmonary resuscitation must be attended on an annual basis. In addition to these mandatory study days, there is a requirement for practitioners to demonstrate
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evidence of continuing professional learning by attending study sessions relevant to their areas of clinical practice. For example, a district nurse may choose to attend a tissue viability study day and then write a short reflective account which enables him or her to consider how this knowledge can be applied within clinical practice. In the reflection, the date and number of hours must be recorded to ensure that the minimum of 35 hours is reached over 3 years

- **Life events:** This section may include an aspect of family life that has had some impact on an individual’s working life. For instance, changing jobs or completion of a period of study that has resulted in new and challenging responsibilities

- **Critical incidents and personal reflection:** These are incidents that the nurse has observed and/or taken part which have affected him or her, for instance looking after a patient who subsequently dies. The positive aspects of learning are not always apparent at the time. However, by using a framework such as the Gibbs reflective cycle (1992), an individual can look retrospectively at the incident and analyse his or her subsequent learning (Hogston and Simpson 2002)

### Duty of care

The concept of duty of care is complex. Here a brief overview is provided; however, it must be remembered that duty of care is always context dependent. *The Code* (NMC, 2008a) applies directly to registered nurse practitioners; however, the principles that it sets out of good practice and duty of care apply to all those directly involved in patient care. Duty of care, according to Lord Atkin (1932), can be seen as:

reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour.

The definition of what is reasonable originated from the Bolam test in 1957, where the case of *Bolam v Friern Hospital Management Committee* [1957] resulted in the following legal ruling:

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 competent man exercising that particular art.

The case of *Wisher v Essex AHA* [1988] is the current standard used to define reasonable care with respect to students and junior staff:

The standard is that of a reasonably competent practitioner and not that of a student or junior.
Fitness to practise

Fitness to practise enables a nurse or midwife to practise as a registrant without restriction. Grounds for an individual being considered unfit to practise are identified by the NMC (2008a):

- Misconduct
- Lack of competence
- A conviction or caution (including a finding of guilt by a court martial)
- Physical or mental ill health
- A finding by any other health or social care regulator or licensing body that a nurse’s or midwife’s fitness to practise is impaired

Nurses and accountability

Accountability is another complex concept. This section only begins to outline some of the issues associated with accountability.

The government

In addition to their responsibilities to the regulatory body of the NMC, nurses are accountable to the ‘stakeholders’, that is, the general public and the government to provide effective, efficient, high-quality care.

Since the inception of the NHS in 1948, much debate has surrounded government funding and target setting. Government targets such as reductions in waiting lists and additional financial resources for certain services such as a winter bed crisis inflame political opinion and debate about the cost-effectiveness and the quality of patient’s provisions. Present-day government initiatives to involve the public in the development of a health care service for the twenty-first century are discussed later in this chapter.

The general public

Nurses are accountable for the delivery of appropriate care to patients within a variety of care settings. The level of expertise at which an individual delivers this care will vary, depending upon the education that they have received. In The Code (NMC, 2008a), the registered practitioner’s delegation of responsibility to unqualified staff, and the accountability of that registered practitioner, is stated thus:

The delegation of nursing or midwifery care must always take place in the best interests of the person the nurse or midwife is caring for and the decision to delegate must always be based on an assessment of their individual needs.

Consequently, those involved in patient care should undertake only those tasks for which they have received appropriate education. In the case of delivering fundamental
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nursing care, this may be a part of formal programme of study such as the National Vocational Qualification (NVQ) in health care studies.

The employer

Finally, nurses are accountable to their employer under a contract of employment. Under terms of employment there is an understanding that the nurse will act in a responsible manner when carrying out his or her duties. NHS trusts have their own policies and procedures, which are designed to ensure that patients are protected from harm. The term 'vicarious liability' refers to situations whereby the employer accepts responsibility for the fault of its employees. However, if the employee is found not to have followed accepted procedure or protocol, for example the trust’s drug administration policy, then the trust is not legally liable for the employee's error. Vicarious liability is fraught with legal technicalities and further reading in this area is encouraged.

Nursing hierarchy

Within a clinical setting it is common to find the nursing hierarchy as given in the following subsections, wherein the roles and responsibilities of nurses holding these titles are also described (see Figure 1.1). The titles used here may vary depending on the setting.

Modern matron

The modern matron is responsible for managing, leading and developing care services normally within a clinical directorate, for example community services. The modern
matron will have significant experience and clinical expertise within the field that they are working, facilitating nursing developments and contributing to the Trust and Directorate Clinical Governance strategy.

**Ward manager**

The ward manager is responsible for the 24-hour delivery of care to patients within a designated care setting. The ward manager is sometimes referred to as sister (female) or charge nurse (male). Consequently, a ward manager will have a wide range of responsibilities: those may vary from the day-to-day management of an off-duty rota to the management of a ward’s budget. The ward manager may be responsible for the recruitment and selection of new members of staff. A part of their role is to ensure that all staff members develop and retain appropriate clinical skills; thus, the ward manager must enable qualified and unqualified staff to attend clinical study days which meet their professional and academic needs. Such development objectives may be highlighted during the yearly appraisal cycle, and the ward manager is responsible for ensuring that these are met. The ward manager may also be actively involved in clinical audits and formulating policies and procedures related to their field of expertise.

**Deputy ward manager**

The deputy ward manager (sometimes known as the team leader) is a registered nurse with at least 2 years of experience as a Band 5 senior staff nurse, and has an appropriate secondary qualification, gained through post-graduation qualifications and experience. A deputy ward manager will be expected to undertake the management of a designated clinical environment. In addition, he or she may be involved in the implementation of government directives such as ‘the fractured neck of femur pathway’ (NHS Plan, 2000). A deputy ward manager will be required to supervise and develop the clinical expertise and competencies of junior members of nursing staff, for example newly qualified staff nurses, student nurses or health care assistants. It is common for a deputy ward manager to hold the mentorship and preceptorship certificate in areas where student nurses are allocated.

**Senior staff nurse**

A senior staff nurse is typically a registered nurse with at least 12 months of experience as a junior staff nurse. Senior staff nurses are responsible for ensuring that safe, appropriate care is delivered to patients and their families. In carrying out their duties, senior staff nurses are required to assess, plan, implement and evaluate the care that is provided to patients over a recognised time period, for instance during an early duty. In carrying out their duties, senior staff nurses are expected to take an active role in liaising with other members of the multidisciplinary team, such as doctors, physiotherapists, district nurses and general practitioners. Senior staff nurses will actively engage with student nurses, fulfilling the role of assessor/mentor, once the mentorship and preceptorship qualification has been successfully completed.
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Junior staff nurse

The title of junior staff nurse relates to newly qualified staff nurses with current NMC registration and health and social care experience, albeit as a student nurse. The qualified nurse works within codes of practice and professional guidelines, planning nursing care for patients and their families and managing the work environment as required. The junior staff nurse utilises professional and clinical knowledge that he or she has acquired through registration.

Senior health care assistant

A senior health care assistant will have successfully completed the Level 3 NVQ in health care studies. The role of a senior health care assistant is to provide fundamental care to patients under the supervision and direction of a qualified practitioner, to accurately record patient information and to supervise more junior members of the team.

Junior health care assistant

The health care assistant will have successfully completed NVQ at Level 2 or will be undertaking this qualification. A junior health care assistant will deliver personal care to clients within a variety of care settings under the supervision of senior team members.

Student nurse

A student nurse will be undertaking a 3-year pre-registration nurse education programme; upon successful completion of the programme of study, the student nurse will be eligible to register with the NMC as a registered nurse. The first year of education known as the 'common foundation programme' enables all students, irrespective of their destined branch, to study together. During the second and third years of the programme of study, the student nurse will study theoretical subjects that directly relate to their chosen field of nursing. During these 3 years students will experience a variety of clinical settings and develop a sound theoretical knowledge base which enables them to apply theoretical knowledge to practice, equipping them for their role as registrants.

District nurse

A district nurse assesses patients within a community setting; it may be the client's home, general practice setting or a residential care home. A district nurse will plan and implement care, maintain associated records and coordinate the workload of the team of which he or she is a member. District nurses are registered nurses who have successfully completed a specialist practitioner programme at degree level.
Health visitor

A health visitor usually works with families with specific health and social needs, and consequently liaises as and when appropriate with other health professionals and agencies such as social services. Health visitors run child health clinics, providing advice and health education to parents of babies and young children; they also work with patients who suffer from a disability or chronic illness. Health visitors are registered nurses or midwives who have successfully completed a health visitor programme at degree level.

Practice nurses

Practice nurses work in general practitioner surgeries as part of a team, which will include doctors, and, depending upon the size of the practice, may involve working with other members of a multidisciplinary team, such as physiotherapists, pharmacists, dieticians and other nurses. Practice nurses are registered nurses who have undertaken an additional training as identified by the general practitioner who is their employer.

Nurse consultants

These nurses are experienced registered nurses who have chosen to specialise in a particular area of health care. Nurse consultants spend 50% of their time on direct patient care, ensuring that the high level of nursing expertise that they possess is utilised in the direct delivery of care. Nurse consultants are also actively engaged in the education, training and development of colleagues and are involved in research and evaluating care that is delivered.

Government directives

In this section current government directives are described; the government lays down statutes in law which relate directly to clinical practice.

Clinical governance

Each individual NHS Trust’s board of governors is responsible for ensuring that safe and acceptable standards of care are delivered in all areas of clinical and non-clinical practice. They are required to do this through framework (DH, 1998). NHS organisations are accountable for continuously improving the quality of their services.

Data Protection Act 1998

This Act sets out eight principles which apply to the keeping of computerised data and certain types of manual records that includes health records; personal data is clearly defined as data ‘which relates to a living individual’. Employers are responsible for ensuring that data collection systems comply with the provisions as set out within the Act.
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Dimond (2008) notes that the principles are designed to ensure that any personal data must be accurate, relevant, held only for specific defined purposes for which the user has been registered, not kept for longer than necessary and not disclosed to those who are unauthorised.

Our Healthier Nation

An action plan to tackle poor health was provided in the form of the government report *Our Healthier Nation* (DH, 1999); aims were set out to improve the health of the nation as well as the health of the worst off in particular.

In this document the government had put forward the following four targets to be achieved by 2010:

1. Reduction in the death rate associated with cancer, in those under 75 years by at least a fifth
2. Reduction in the death rate associated with coronary heart disease and stroke, in those under 75 years by at least two fifths
3. Accidents and serious injury to be reduced by a tenth
4. Reduction in the death rate associated with suicide to be reduced by at least a fifth in line with overarching objectives related to the treatment of mental illness

The government explained how they intended to achieve these objectives, principally by increasing funding and encouraging the development of local health initiatives (DH, 1999); there was to be a ‘new balance’ in which people, communities and the government would work in partnership to improve the health of the nation.

National Institute for Health and Clinical Excellence

One of the functions of NICE, which was set up in 1999, is to disseminate good clinical practice throughout the NHS, and offer guidelines in relation to research-based practice. In England, NICE produces guidance in three areas of health through the following three centres:

- **Centre for Public Health Excellence**: Develops public health guidance on the promotion and the prevention of ill health
- **Centre for Health Technology Evaluation**: Develops technology appraisals and interventional procedure guidance. Technology appraisals are recommendations on the use of new and existing medicines and treatments within the NHS. Interventional procedure guidance evaluates the safety and efficacy of such procedures which are used for diagnosis or treatment
- **Centre for Clinical Practice**: Develops clinical guidelines. These are recommendations based on the best available evidence on the appropriate treatments and care of people with specific diseases and conditions (NICE, 2007)
National Health Service Plan (a plan for investment, a plan for reform)

This plan sets out specific targets for NHS trusts to achieve within documented time frames. For example, ‘the fractured neck of femur pathway’ is the integrated care pathway that aims to effectively and efficiently manage the patient’s progression from accident and emergency department to discharge. Within the provision of this ‘fast-track care’ is the involvement of members of the multidisciplinary team, such as physiotherapists, occupational therapists, social workers, doctors, nurses, district nurses and hospital-at-home services. The ultimate aim, according to Komaromy (2001), is for those patients to have a shorter inpatient time and an improved community support network on discharge.

Health Care Commission 2004

The Health Care Commission’s remit is to review the quality of care that is at present provided across the NHS and the independent sector. With the aim of ensuring that the care that is provided meets the prescribed recognised standards, for instance benchmark statements, NICE has set out standards of clinical excellence. The Health Care Commission informs patients, the general public, health service employees and health professionals about changes and improvements to local health care provision (DH, 2004a).

Standards for Better Health

The document Standards for Better Health (DH, 2004b) outlines the seven domains of care against which all providers of health care are measured:

1. Safety
2. Clinical and cost-effectiveness
3. Governance
4. Patient focus
5. Accessible and responsive care
6. Environment and amenities
7. Public health

In each of the above domains noted are the ‘core standard’, which sets a minimum level of service, and the ‘developmental standard’, which provides a framework for the improvement of care delivery.

The Health Care Commission and the Commission for Social Care Inspection utilise these domains and standards to ensure that minimum standards of care are delivered across all providers of care, irrespective of whether the care is delivered within NHS, Foundation Trust, or private or voluntary sector (DH, 2004b).

NHS’s Job Evaluation Handbook

This handbook (DH, 2004c) sets out the job evaluation scheme, which is to help ‘ensure that all staff are rewarded fairly and that the NHS respects the principles of equal pay for
work of equal value', thereby enabling employers, employees and staff representatives to determine the point of transfer from clinical grades to pay bands (DH, 2004c; Royal College of Nursing [RCN], 2005), for example from 'E grade' staff nurse to Band 5, Point 24 staff nurse. The handbook considers job evaluation factors and the skill level required to fulfil a named post.

**Agenda for Change**

The underpinning principles of *Agenda for Change* are the harmonisation of terms and conditions for all NHS employees (DH, 2004d). *Agenda for Change* was implemented across the UK on 1 December 2004. It aimed to address the issue of equal pay for work of equal value; central to the *Agenda for Change* is the Knowledge and Skills Framework (KSF).

**Knowledge and Skills Framework**

The KSF is integral to the government’s *Agenda for Change* policy (DH, 2004b). It is designed to support career progression and the personal development of staff working within patient care, ensuring that developmental objectives are clear and appropriate. Doctors and dentists are not included in this framework. The KSF defines and describes the knowledge and skills that are required by staff and are appropriate to their role and level of professional responsibility. The KSF enables individuals to identify skills acquisition that will support their career progression. It is envisaged that all staff will progress through a named band on an annual incremental basis. Each pay band has a series of incremental pay points and two gateways, which are identified in job descriptions. The KSF is made up of core and specific dimensions; each dimension comprises at least four levels or indicators (DH, 2003, 2004c; RCN, 2005).

**Core dimensions**

These dimensions are core to the work of everyone who works in the NHS:

1. Communication
2. Personal and professional development
3. Health, safety and security
4. Service and developments
5. Quality
6. Equality, diversity and rights

**Specific dimensions**

These dimensions can be applied to define parts of different posts. They are grouped into four categories:

1. Health and well-being
2. Information and knowledge
3. General
4. Estates and facilities
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Gateways

Foundation gateway
This gateway falls within the first 12 months of appointment to any post irrespective of the band, and aims to ensure that the individual is able to fulfil the role concerned.

Second gateway
This occurs at a fixed point, normally near the top of a pay band, for example Band 5 staff nurse (DH, 2004c; RCN, 2005). This gateway is a formal review; its purpose is to ensure that the individual is able to fulfil the roles and responsibilities consistently as set out in the job description.

National Service Frameworks

National Service Frameworks (NSFs) are ‘long-term strategies for improving specific areas of care’. Currently there are ten NSFs. Within each of these frameworks, the DH has set out a national standard and identified key interventions, for example long-term conditions (DH, 2005). The DH (2000) states that the NSFs will set out standards to suggest how care can be improved, for example, with regard to neurological services across the board so that a first-class service can be delivered over the next 10 years to everyone who has a neurological condition.

High Quality Care for All: NHS Next Stage Review

This report (DH, 2008a) sets out the challenges facing the delivery of effective, efficient and appropriate health care in the twenty-first century. Key challenges are identified, which are summarised as an increase in expectations, demand that is driven by demographics, a continuing development of an ‘information society’, advances in treatment and care, the changing nature of disease as well as the changing expectations of the health workplace.

An NHS is needed that provides patients and the public with more information and choice, works in partnership with local health authorities and has high-quality care at its heart. The NHS must be flexible, responding to the needs of local communities.

The structure of the NHS in England

Department of Health
This Department supports the government in its plans to reform and provide an integrated and comprehensive range of services that is based on clinical need, not the ability to pay.

Modernisation Agency
Established in 2001 the agency’s remit is to develop ‘patient-centred service that gives power to its staff and patients at all levels’ (DH, 2008c). This agency has two core functions: firstly, to ensure that the NHS meets the needs of its patients in the twenty-first
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century; and secondly, to modernise services in an appropriate and meaningful manner so that the services that the general public require are easily accessible and available. The Modernisation Agency is expected to achieve this objective by the integration of services and the development of best practice throughout the NHS.

Primary care trusts

Primary care trusts (PCTs), according to the DH (2008b), have a key role to play in assessing local needs and also have a responsibility to commissioning care. PCTs manage local health care services; within a primary care group are general practitioners, dentists, opticians, pharmacists and NHS Direct. The function of PCTs is to ensure that there is adequate provision of services for the general population, and this could be NHS hospital services and the inpatient and outpatient provisions, or the NHS walk-in centres and mental health services. They control 80% of the total NHS budget.

Strategic health authorities

In 2002, 28 strategic health authorities were created. Following re-organisation in 2006, this number decreased to 10. At present, their function is to manage local health care services; strategic health authorities achieve this by developing local improvement plans and ensuring that national priorities such as the development of an integrated stroke care pathway are actively supported (DH, 2008b).

Care trusts

At present, only a small number of care trusts are in existence (DH, 2008b). Their function is that of joint collaboration between the NHS and local health authorities, specifically where a closer working relationship is considered to be of benefit for the provision of local health care services.

Mental health trusts

They provide a range of psychological therapies such as bereavement counselling, general health screening within the local community and inpatient health care provision for clients, with a range of mental health diagnoses (DH, 2008b).

NHS trusts

Acute trusts

Acute trusts manage hospitals and formulate strategies for the improvement of hospital services. They are also the employers for hospital staff such as doctors, nurses, midwives, health visitors and allied health professionals, for example physiotherapists and radiographers.

Foundation trusts

Foundation trusts are NHS hospitals which have been given a degree of financial and operational independence (DH, 2008b). The trusts remain under the overarching umbrella of the NHS; however, they are run by members of the public, staff and locally based
managers who are able to tailor the services that they provide to the needs of the local population.

**Ambulance trusts**

Thirty-three ambulance services cover England, providing access to emergency health care for the general population (DH, 2008b). The ambulance service operates on three levels, ranging from immediate life-threatening to non-emergency response. Under government strategic plans, certain criteria are set which relate to the response time.

**The structure of the NHS in Scotland**

In Scotland the Scottish Government Health Directorate is responsible for NHS Scotland and the provision and development of community-centred care. The responsibilities of the Scottish Government Health Directorate also include the ambulance service; the state high security hospital; NHS 24, which provides 24-hour telephone advice service within Scotland; NHS Health Scotland; NHS Education for Scotland; NHS Quality Improvement Scotland, which monitors clinical standards; and the National Waiting Times Centre Board (DH, 2008d).

**The structure of the NHS in Wales**

Within Wales, NHS services are delivered to the Welsh people via local health boards and NHS trusts. Primary, secondary, tertiary and community care services are provided in a format similar to that of England.

The Welsh Assembly allocates resources to the local health boards. The Health Commission Wales finances inpatient and outpatient care. Health of Wales Information Service provides an NHS Wales Directory, which includes contact details of health providers, health watchdog, public health information and an online health encyclopaedia (DH, 2008e).

**The structure of the NHS in Northern Ireland**

There are four health boards within Northern Ireland: Eastern, Northern, Southern and Western Health, as well as Social Services Board. The responsibility of commissioning services is to meet the ever-changing needs of the population who lives within Northern Ireland.

Acute and community NHS services are provided to the population via five health and social care trusts (DH, 2008f):

1. Belfast
2. Northern
3. Southern
4. Western
5. South Eastern
Conclusions

In this chapter a generalised overview of the nurse’s roles and responsibilities in the twenty-first century has been discussed. The role of the NMC in relation to the regulation of pre- and post-registration nurse education has been explained, as has the nurse’s fourfold responsibility: firstly, to the general public; secondly, to their professional organisation (NMC); thirdly, to the government; and finally, to their employer.

The importance of lifelong learning and reflective practice has been introduced and the causes and consequences of changing government directives in relation to the patient’s choice have been briefly discussed.

Glossary

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<td>Nursing and Midwifery Council</td>
<td>Professional regulatory body for registered nurses and midwives</td>
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Our Healthier Nation

Four government targets to be achieved by 2010

Personal portfolio
Evidence that continuing professional development has taken place

Primary care trusts
Managing local services, e.g. general practice and commissioning NHS hospital services

Secondary care
Acute care

Sign-off mentor
Mentor who makes final clinical assessment at the end of pre-registration programme

Standards for Better Health
Seven domains of care against which all providers of care are measured

Student nurse
Individual undertaking a 3-year programme of study leading to registration

Strategic health authorities
Manage local NHS services

Unfit to practise
Criteria under which a nurse may be referred to the NMC

Vicarious liability
Employer accepts responsibility for the fault of its employees, proving that they have followed recognised protocol

Post-chapter quiz

1. Explain the key functions of the Nursing and Midwifery Council, giving an example of each
2. What action would you take if you considered that someone was not ‘fit to practice, fit to purpose’?
3. Who is accountable for the actions of a health care assistant?
4. Who is accountable for the actions of a staff nurse?
5. What do you understand by the term ‘Agenda for Change’?
6. What do you understand by the term ‘Data Protection Act’?
7. What does the term ‘promotion gateway’ mean?
8. List how you might empower an individual
9. Why is the Bolam test (1957) important?
10. What do you understand by the term ‘vicarious liability’?

References

18 Nursing Care and the Activities of Living

Nursing and Midwifery Council (2006a) Standards for Mentors, Practice Teachers and Teachers. London: NMC.
Nursing and Midwifery Council (2006b) Standards to Support Learning and Teaching in Practice. London: NMC.
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