Professionalism and Professional Accountability in Clinical Skills Practice
# Professionalism and Professional Accountability in Clinical Skills Practice

## Contents

<table>
<thead>
<tr>
<th>Professionalism and Professional Accountability in Clinical Skills Practice</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1</td>
<td>1</td>
</tr>
<tr>
<td>Rationale for the Professionalism and Professional Accountability in Clinical Skills Study Guide</td>
<td>1</td>
</tr>
<tr>
<td>How to Use this Study Guide</td>
<td>1</td>
</tr>
<tr>
<td>Evaluation:</td>
<td>2</td>
</tr>
<tr>
<td>Aim</td>
<td>2</td>
</tr>
<tr>
<td>Learning Outcomes</td>
<td>2</td>
</tr>
<tr>
<td>Background</td>
<td>3</td>
</tr>
</tbody>
</table>

### Section 2

1. Recognise key principles of professional accountability in relation to safe clinical skills practice | 5
   - Defining Accountability | 5
   - Areas of Accountability | 6
   - Who Are You Accountable To? | 7
   - Profession | 7
   - Employers | 7
   - Keeping Up To Date With Hazard Notices and Safety Action Bulletins | 8
   - Awareness of Safe Practice | 9
   - Accountability and the Employee Role | 9
   - Delegation and Accountability | 10
   - The Principles of Delegation | 11

2. Analyse the underlying ethical principles related to safe decision making in clinical skills practice | 12
   - Ethical Aspects | 12
   - Self Awareness | 12
Why Use An Ethical Framework In Practice? ........................................ 13
Ethical Theories ................................................................................ 13
Consequentialism .............................................................................. 13
Duty based / Deontology ................................................................. 13
Virtue Ethics .................................................................................... 13
Ethics of Care .................................................................................. 14
Principlism ....................................................................................... 14
Consent and Communication ............................................................ 15
Consent ............................................................................................. 15
Voluntary Consent .......................................................................... 17
Example of Consent ......................................................................... 18

3. Identify own professional clinical skills practice in accountability as a practitioner.... 19
Evidence-Based Practice/Knowledge ............................................... 19
Codes of Conduct ............................................................................. 19
What professional criteria do we need to be accountable? ............. 20
Knowledge ....................................................................................... 21
Skills ............................................................................................... 21
Competence .................................................................................... 22
Context ............................................................................................ 23
Chaperone ....................................................................................... 23

4. Demonstrate an understanding of legal aspects related to the professional practice of
clinical skills .................................................................................... 25
Professional and Legal Aspects ....................................................... 25
Child/Neonatal Considerations ....................................................... 25
Accountability and Legal Aspects .................................................. 26
Duty of Care .................................................................................... 27
Vicarious Liability and Legal Aspects .......................................... 28
Capacity .......................................................................................... 29

5. Demonstrate a professional approach to safe documentation (both written and
electronic) in the context of clinical skills practice .......................... 30
Good Practice in Professionalism in the Digital Age .................................................. 30
Patient Data in a Technological Age ........................................................................... 30
Searching the internet ............................................................................................... 30
Social Networking: e-professionalism advice .............................................................. 30
Documentation ......................................................................................................... 30
Section 3 ...................................................................................................................... 33
Theoretical Assessment ............................................................................................... 33
Case Scenarios - What Can Go Wrong? .................................................................... 33
Scenario 1: Venepuncture .......................................................................................... 33
Scenario 2: Peripheral IV Cannulation ....................................................................... 34
Scenario 3: IV medicines administration ................................................................... 35
Scenario 4: Infusion Devices ....................................................................................... 36
Scenario 5: Immunisation ........................................................................................ 37
Scenario 6: Ear Irrigation ......................................................................................... 38
Section 4 ...................................................................................................................... 39
Appendix 1: Accountability and KSF ....................................................................... 39
Appendix 2: Scottish Credit Qualification Framework (SCQF) and accountability ...... 40
SEWS Chart Example ............................................................................................... 41
Resources and References ......................................................................................... 42
References: per Skills Aspect .................................................................................... 44
Further Reading ......................................................................................................... 45
Authors, Contributors & Reviewers .......................................................................... 47
Reviewers 2013/2014: ............................................................................................... 47
RECORD OF COMPLETION OF PROGRAMME ......................................................... 48
(Professionalism and Professional Accountability in Clinical Skills Practice) .............. 48
Section 1

Rationale for the Professionalism and Professional Accountability in Clinical Skills Study Guide

This good practice study guide has been developed by authors from different health care professions to enable practitioners to develop their knowledge, skills, values and attitudes of professional issues embedded in acquiring and practising clinical skills. Adopting a multi-professional approach to clinical skills training will promote standardised practice in the delivery of health care procedures, will encourage effective working relationships and will provide patients with access to multi-skilled, flexible health care practitioners.

The study guide is suitable for any health care practitioner currently working in the NHS, in the UK who is involved as part of their work in the delivery of procedural clinical skills.

How to Use this Study Guide

This Good Practice Study Guide will support participants in their studying, enabling them to work at their own pace; learning about professional issues in the context of their own practice. It will also encourage participants to become aware of related professional issues that affect other health care practitioners.

Each participant should negotiate a suitable time frame for completion of the suggested activities contained within the study guide with their assessor. Participants should aim to complete the study guide within a six week time frame.

Demonstrating a professional approach to practice underpins the delivery of all procedural skills in health care. This professionalism and professional accountability study guide should therefore be completed before accessing any procedural clinical skills packs. As participants develop their role or review their procedural skills using a procedural clinical skills pack, they may wish to revisit this core programme. This pack should also be used independently as a study guide to professionalism and professional accountability as a whole, not just related to the acquisition of skills.

Throughout the text, activities are provided which will encourage the use of reflective, decision-making, observational and cognitive skills.

Please identify a safe place to keep your Professionalism and Professional Accountability in Clinical Skills Study Guide, as subsequent clinical skills training will require you to refer back to this material. It may be useful to keep it in your appraisal folder.
Assessment includes:

- Practitioners should attempt the theoretical assessment after working through the package.

- Answers to theoretical assessments must be checked by the assessor using the marking guide provided. Assessors should guide practitioners to reference material in the resource pack if the practitioner does not provide similar answers to the marking guide.

Evaluation

We would like to know what you thought of the pack by taking a few minutes to fill in the evaluation form on completion. There is an electronic version which can be accessed here.

Aim

The aim of this workbook is to explore aspects of professionalism and accountability and the implications for professional practitioners, e.g. medics/nurses/midwives/allied health practitioners. Health care practitioners using this pack should refer to their own professional body and code (e.g. NMC, GDC, HPC). This resource has been adapted from NHS Lothian Accountability workbook and NHS Tayside, NHS Fife and University of Dundee workbook on Professionalism.

For the purposes of this workbook a clinical skill is defined as

“Any action by a healthcare professional involved in direct patient care which impacts on clinical outcome in a measurable way”

NHS Education for Scotland (2008)

Prior to any clinical skill education which you undertake either using simulation or online resources it is essential that you complete this workbook. This will ensure you are aware of the standards expected when you undertake any clinical skill on a patient. It is advised that you complete the action boxes and scenarios. This will then underpin any of the clinical skills education you carry out as part of your ongoing professional development.

Learning Outcomes

By the end of this workbook you will be able to:
1. Recognise key principles of professional accountability in relation to safe clinical skills practice

2. Analyse the underlying ethical principles related to safe decision making in clinical skills practice

3. Identify your own professional clinical skills practice in terms of your accountability as a practitioner

4. Demonstrate and apply an understanding of legal aspects related to the professional practice of clinical skills

5. Demonstrate a professional approach to safe documentation (both written and electronic) in the context of clinical skills practice.

**Background**

Quality in health care is described as having six dimensions (Scottish Government, 2010; Institute of Medicine, 2001):

- safe
- effective
- patient-centred
- timely
- efficient
- equitable

Despite a worldwide commitment to providing reliable quality healthcare 10% of hospital admissions still result in unintended harm. Patient safety is related to quality of care and is concerned primarily with the avoidance, prevention and amelioration of adverse events from the practice of health care.

From studies such as the Harvard Medical practice study undertaken in the 1990s (Baker, 2004) there is now emerging evidence that safety develops from the interaction of components in a system. In other words safety doesn’t reside in a health care professional, equipment device department or organization (National Patient Safety Foundation, 2011). Professional accountability is changing within health care and the knowledge we have from patient safety and quality improvement has informed this dynamic change.

In the 1980s we saw the advent of managed care where clinicians gained responsibility and accountability for their own budgets. In the 1990s charters and service quality guarantees were generated as the rights of service users were incorporated (Department of Health...

Following the recent Mid-Staffordshire inquiry (Francis, 2013) which highlighted how the health care system has failed patients, the issue of accountability and quality of the public services has been scrutinised. Such system wide failures in the delivery of health care are not common and there is an overriding need to identify issues early through common reporting standards so to have clear and efficient systems in place to reduce patient risk to a minimum.

The implementation of clinical governance links quality to accountability and sets out a requirement for all NHS services to establish the culture systems and leadership to enable quality to be assessed so that opportunities for improvement can be implemented (Department of Health, 1998).

One of the other dimensions of quality, patient centredness, is now more widely referred to as person centredness. What this concept addresses is the reductionist approach that had crept into healthcare over the last 40 years seeing a person as an illness or a task rather than able to make their own choices. Person centredness recognizes the intrinsic worth of a person and the environment in which they live i.e. their humanity (McCormack, 2004). The new NHS strongly promotes the rights and expectations of patients as consumers of health services expanding our concept of accountability to patients, for example, waiting time targets. There is a clear drive in all NHS organisations whether in primary or secondary care to improve the patient’s experience.

There is a new, more diverse form of accountability emerging which is bringing a new style of multidisciplinary practice, has more patient participation and where all NHS staff are expected to embed a culture of safety in their own local organization as part of their commitment to clinical governance. The key to clinical governance is trust which can then enable systems to be changed and to be fit for purpose and have the capability to recognize poor performance early.

This workbook explores individual accountability in the system for safe reliable high standards of clinical skills practice recognizing there are nine regulatory bodies representing health care professionals in the NHS.
Section 2

1. Recognise key principles of professional accountability in relation to safe clinical skills practice

**Action Box 1**

a) What does the term accountability mean to you?

Tingle (2004) suggested that there is no universally agreed definition of the term “Accountability” and proposed the essential flavour would seem to be that of answerability, i.e. giving a reasoned account for one’s own actions or omissions.

Dimond (2004) stated that if we accept that most actions and omissions are based on the exercise of judgement, accountability means that health care practitioners making those judgements have to be able to explain the basis on which they were reached, i.e. provide a rationale. Professionally, this relates to any aspect of care given to patients, e.g. carrying out ear irrigation (Gallacher & Hope, 2012; Pennels, 1997).

**Defining Accountability**
The term “accountability” within health care is complex and is probably best viewed as having three components:

1. An individual’s professional accountability for the quality of their work
2. The accountability of health professionals within the organisation in which they work
3. Accountability with others for the organisations performance and for provision of services.
Since 2001 a new approach to accountability has been introduced by Caulfield (2005) which identifies four pillars of accountability:

- **First pillar** - professional accountability
- **Second pillar** – ethical accountability
- **Third pillar** – legal accountability
- **Fourth pillar** – employment accountability.

The NMC (2009a) stated that professional accountability is integral to professional practice, and is fundamentally concerned with weighing up the interests of patients and clients in often complex situations, whilst using professional knowledge, judgement and skills, based on evidence, to make a decision.

As a registered health care practitioner you are required to make judgements in a wide variety of circumstances (GMC, 2013; NMC, 2011) and are accountable for all actions you carry out in the course of your professional duties: you may be called to account at any time for your practice or omissions.

**Areas of Accountability**

Over the last 30 years, accountability has received increasing attention from the health care field, society and professional practitioners. Accountability requires each registered practitioner to explain and justify his/her actions and clinical decisions or to be called to account. This means that practitioners are answerable for their actions and omissions or departure from good professional practice, regardless of advice or direction from another professional (NMC 2008; GMC 2013).

In law, there are four areas whereby the practitioner may be called to account for his/her actions/decisions. These include:

- **Accountability via Civil Law** - concerned with disputes between private individuals e.g. relatives/patient versus nurse/doctor
- **Accountability via Criminal Law** - breaching statute or common law precedent
- **Professional accountability** - through codes of conduct and frameworks
- **Accountability to employer** - via contract law.

**EACH REGISTERED PRACTITIONER MUST BE FULLY COGNISANT OF HIS/HER LEGAL RESPONSIBILITIES IN RELATION TO THE ROLE AND DUTY OF CARE OWED TO PATIENTS.**
As the role of the practitioner evolves, so too must the professional aspects of accountability and codes of conduct must be refined to prepare practitioners to acquire skills and to manage advances in modern health care.

Who Are You Accountable To?

**Profession**

Health care professionals have a formal obligation in relation to accountability which is placed upon them by their regulatory councils i.e. the NMC.

The standards set by the NMC are embodied in the Code (NMC, 2008), which is the template of good practice against which registered nurses/midwives would be measured in the event of professional misconduct.

The GMC in Good Medical Practice (2013) also sets out expected standards in relation to quality and accountability. The care, safety and dignity of patients are the primary duties of any medical professional. However the GMC also highlight the duty a medical professional has to the profession, the wider community and the organization in which one is working.

**Employers**

Health care practitioners are also accountable to their employer. An employee is one who works to contract rather than providing services for payment. There is an assumption that employer and employee goals are the same. However where professional and employer’s opinions differ, you must choose how you will act in these instances in relation to competing arenas of accountability. In a similar vein the General Medical Council identifies that each doctor should establish the scope of their role and responsibilities with their employer including non-clinical responsibilities.
Action Box 2

a) Can you think of a situation, which may arise, within your practice where there may be a conflict of accountability?

b) What options would you have to consider regarding this situation?

The NMC (2008) stated that:

“--- you must act as an advocate for those in your care, helping them to access relevant health and social care, information and support”.

Reporting and monitoring are essential, and many skills are now being audited and can form part of clinical quality processes, e.g. the care bundle in peripheral cannula (PVC) maintenance, which ensures safe practice. The Scottish Patient Safety Programme is central to putting into place robust safety systems, e.g. the Scottish Early Warning System (SEWS) and Situation Background Assessment Recommendation (SBAR).

Keeping Up To Date With Hazard Notices and Safety Action Bulletins

It is essential to learn from incidents both locally and nationally in order to put systems in place to help prevent further occurrences of preventable incidents. The Adverse Incident Reporting & Investigation Centre (IRIC) is a section of NHS National Services Scotland. IRIC coordinates the investigation of incidents involving health, social care, estates and facilities equipment across NHS Scotland, pursuing investigations involving medical devices and estates equipment until a satisfactory outcome is achieved. IRIC issues safety warnings.
including Hazard Notices and Safety Action Notices, and works closely with the Medicines and Healthcare Products Regulatory Agency (MHRA) in England and Wales.

Hazard Notices were top priority safety warnings and Safety Action Notices were standard priority safety warnings issued in Scotland from 1995 to 2009. Both have been largely superseded by Medical Device Alerts (from the MHRA). From 1 April 2008 Medical Device Alerts published by the Medicines and Healthcare Products Regulatory Agency (MHRA) in England were adopted as guidance for NHS Scotland and Local Authorities in Scotland.

An archive of Hazard Notices, Safety Action Notices and Medical Device Alerts is available via the Health Facilities Scotland website. Clinical Alerts are normally cascaded to staff. These are sent to the senior nursing managers but must be made available to all users of devices – it is your manager’s responsibility to ensure that this information is disseminated and any appropriate action is taken in your area. However, you also have a personal responsibility to seek out the notices and familiarise yourself with any identified risks. Within blood and blood products transfusions, the Serious Hazards of Transfusion (SHOT) is the applicable reporting agency and publishes an annual report, outlining the risks and errors reported.

**Awareness of Safe Practice**

Safe, practice is integral to the provision of quality care. Each patient should be treated as an individual so their needs are assessed and met. Therefore care and treatment is based on each individual’s history and circumstances and is not provided as routine treatment or care (Rodgers 2009).

There are common standard reporting systems in place in order to capture near misses as well as adverse events in the process of care. This data can then be anonymised and used to support and disseminate learning. There are a number of analyses tools used to identify the root cause of any incident reported (i.e. Root Cause Analysis: Fishbone Diagram, NPSA, 2010)).

**Accountability and the Employee Role**

An employee must be clear about their role and performance requirements and have at least an annual review of their performance, using professional and personal development review systems. This requires each post to have a job outline and also specified KSF dimensions and levels.

The core dimensions are all relevant to accountability aspects and are core for all practice and clinical skills:
• **Communication**: central for effective practice, e.g. assess competence, gain consent, offer education

• **Personal and people development**: nurses/midwives are required under The Code (NMC, 2008) to develop knowledge and skill, and once competent are expected to support others’ development

• **Health, safety and security**: e.g. carry out effective asepsis, use sharps bins

• **Service development**: e.g. follow policies and guidance to ensure evidence based and effective care is delivered

• **Quality**: e.g. follow appropriate standards

• **Equality, diversity and rights**: e.g. ensure each patient is respected and central to any decisions.

Specific dimensions, e.g. Health and well-being biomedical investigation and intervention would be specific to each practitioner’s role.

**Delegation and Accountability**

Some aspects of practice might be delegated (e.g. asking a support worker to take bloods from your patient) and professional councils outline how you can delegate effectively i.e. the NMC (2008) provide the following guidance:

- You must establish that anyone you delegate to is able to carry out your instructions
- You must confirm that the outcome of any delegated task meets the required standards
- You must make sure that everyone you are responsible for is supervised and supported.

In relation to delegation you may delegate responsibility for an action to another but you remain overall accountable for the care given to the patient.

Whitman (2004) offered an example of delegation and noted that practitioners must ensure any delegated tasks are reported back - if a health care practitioner delegates a task to a support worker, e.g. to take a blood pressure and they do not advise the support worker to report back on the results, then they will be accountable for the poor delegation.

Thus whenever delegating tasks or roles, you must have an understanding both of your own role but also that of the other, so you can ensure you are delegating appropriately, e.g. confirm that the support worker is trained in and competent in venepuncture and also that they understand how and when to report on the results of the task (Whitman 2004).
The Principles of Delegation

The principles of delegation should be:

- To share workload appropriately, so that one person is not overloaded with tasks
- To serve the interests of patients through effective delivery of care from all members of the team
- To develop staff skills in a supported and systematic manner
- To build rapport among team members and increase the purpose and precision of care (Whitman, 2004)
- Delegate appropriately!

Cox (2010) suggested that where a task has been delegated by a more experienced practitioner, who has an overall responsibility for providing care to the patient, that the experienced practitioner may also owe a direct duty of care to the patient to ensure the delegation was appropriate. The following link shares the guidance on delegation of tasks from the NMC.

Action Box 3

a) Who can call you to account in your clinical practice?

b) By what means can you be called to account?
2. Analyse the underlying ethical principles related to safe decision making in clinical skills practice

Ethical Aspects
Before practitioners begin to develop an awareness and understanding of ethical issues in relation to the delivery of clinical skills, they need firstly to focus upon their own value systems. If practitioners understand themselves better, it helps them to be more understanding and accepting of others, both in personal and professional encounters.

Self Awareness
The reason why people form certain values are complex and numerous. For instance, some of the factors which contribute to our beliefs, our values, our opinions and the way we decide about situations may depend upon cultural or socio-political views, religious beliefs, and also life experiences. Values shape our practice - they give life and identity to individuals, professionals and society. Health care professionals are challenged daily with relationships and decisions influenced by patients’ personal values. It is important to be aware of our own personal value systems before adopting different ethical frameworks for our professional practice. Our moral values shape our judgements, decisions and practice. There may be conflict between our professional and personal morals. It is also important to note that practitioners’ value systems may conflict with those of their patients/clients. Knowledge of ethics can assist practitioners to resolve potential conflict.

Doctors and some of the allied health professionals have (until recent changes in education) focused on the biomedical approach to care whereas nurses have focused more strongly on the psychosocial approach to care. Not appreciating the need for both these different perspectives in delivering patient care can raise tensions between different professional groups. Learning to listen to others’ perspectives is not only beneficial for the patient, but for our own ethical development. Paternalism is a term that has frequently been used in relation to doctors’ ethical decision-making in the past, where they tended to make decisions on behalf of patients based on the premise that it was for their own good and they (doctors) were in a position of authority to know best. While this has changed over recent years with patients sharing in the decision making-process, there needs to be a way of reliably measuring the amount of patient involvement in shared decision making (Elwyn et al 2003).
**Why Use An Ethical Framework In Practice?**

Knowledge of ethics helps the health care practitioner to critically evaluate their practice and provides different ways to approach problem-solving and decision-making. This is essential in the process of carrying out a skill where the first steps involve deciding whether it is necessary to perform the skill, whether it can be carried out to benefit the patient with minimal discomfort and risk, and whether the practitioner is aware of his/her level of competence in carrying out the skill without compromising his/her own safety.

General standards of conduct, which make up an ethical system, are known as moral principles. Therefore principles are conceptual tools needed to make moral judgements.

**A Note of Caution:** there are many situations which arise where there are no clear legal guidelines: the dilemmas which arise are of ethical rather than a legal dimension. However, decisions based on an ethical principle rather than a moral opinion will stand greater scrutiny (Rennie et al, 2007).

**Ethical Theories**

Ethical principles provide criteria on which to base judgements in relation to ethical theories. In health care these include beneficence, non–maleficence, respect, fairness, truthfulness and justice. There are a number of ethical theories which are often applied in health care. A few examples are briefly described below for you to consider but these are not exhaustive.

**Consequentialism**

Utilitarianism is a subset of consequentialism, and places moral emphasis on the outcome of an act rather than the act itself, relating to “the greatest good is for the greatest number”. As applied to the development of clinical skills, how the skill is carried out is less important than the outcome.

**Duty based / Deontology**

This ethical theory is based on the work of Kant who placed the moral emphasis on the correctness of an action rather than the outcome. This demands that practitioners do their duty regardless of the consequences but need to make a reasoned choice to do their duty. In applying this to clinical skills, ‘rightness’ of the decision and the skill are emphasised rather than the outcome.

**Virtue Ethics**

This is based on the work of Aristotle and places emphasis on character and habit, identifying in a clinical skills context that through careful training, practitioners
would become virtuous practitioners choosing the best approach to create happiness. There is, however, no defined set of virtues.

**Ethics of Care**

This principle requires the practitioner to assume responsibility for patients/clients and to have the patient’s interests as the priority.

**Principlism**

This applied theory was outlined by Beauchamp and Childress (2001) and identified key principles in ethical decision-making. These have become very popular in healthcare ethics:

- **Autonomy** (respect for the person)
  The right of the individual to self determination and rule...therefore individuals must have freedom to make judgements/decisions and act on the judgements/decisions.

- **Beneficence**
  Carrying out care which will benefit the patient/client with minimal harm.

- **Non-maleficence**
  Above all do no harm. The usual motivation for any intervention is to promote the good for the patient. However, frequently health care professionals concentrate on the beneficent part of the act and omit any consideration of non-maleficence. For example, when carrying out the procedure of venous cannulation, practitioners may consider the benefits to the patient, but may not consider issues associated with cannulation, such as pain or discomfort that the patient may experience during the procedure.

- **Justice**
  Treating people as equals, being fair and just, giving each person his/her due.
Action Box 4

Mrs Brown requires a urethral catheter for post-operative urinary retention. She is confused and following an explanation of the procedure, refuses to be catheterised.

a) With reference to ethical theories and principles, explain what actions you would take in the above scenario?

b) Discuss the ethical aspects you would consider prior to learning a new procedural skill?

In carrying out clinical skills procedures and subsequent role development, professionalism is about applying ethical decision making, whilst abiding by the law. Practitioners should serve the best interests of the patient in a way that minimises errors and maximises patient and practitioner safety.

**Consent and Communication**

Consent must be gained before you begin any treatment or care, you must respect and support people’s rights to accept or decline treatment and care, and people’s rights should be upheld to be fully involved in decisions about their care (NMC, 2008).

The GMC has clear guidelines on consent. These principles include:

1. Listening to patients and respecting their views about their health
2. Discussing with patients what their diagnosis, prognosis, treatment and care involves
3. Sharing information with patients to enable them to make informed decisions
4. Maximizing patient opportunities to make decisions for themselves

There are additional guidelines which are linked to consent and capacity issues which link in with the different legal requirements.

**Action Box 5**

a) What is your understanding of the term valid consent?

b) What would you do if you judged that your patient or client was not legally competent?

c) What is your understanding of the law and a young person’s ability to consent?
For consent to be legally valid, it must be given:

- By patients who have capacity in law
- By patients who are properly informed beforehand (information).

**Consent**

In discussion with the patient, the practitioner seeking consent must present a balanced view in relation to information:

- They must listen to the people in their care and respond to their concerns and preferences
- They must ensure people are informed about how and why information is shared by those who will be providing their care
- They must make arrangements to meet people’s language and communication needs
- They must share with people, in a way they can understand, the information they want or need to know about their health

(NMC, 2008).

To give valid consent the patient needs to understand in broad terms, the nature and purpose of the procedure.

Patients can indicate their informed consent orally or in writing. In some cases, the nature of the risks to which the patient might be exposed might necessitate written consent. Written consent should be recorded with relevant details of the health professional's explanation. It is considered good practice to document communication and discussion with patients (NMC, 2009b).

**Voluntary Consent**

For consent to be valid it must be given voluntarily and freely, without influence or undue pressure to accept or refuse treatment (Lavery, 2003).

Patients may be put under pressure by employers, insurers, relatives or others, to accept a particular investigation or treatment. This should be considered, with other situations in which patients may be vulnerable (GMC, 2008). Before accepting a patient’s consent, you must consider whether they have been given the information they want or need, and how well they understand the details and implications of what is proposed. This is more important than how their consent is expressed or recorded (GMC, 2008).
Example of Consent

Mrs J, a 78 year old patient has been asked to attend her GP for further tests, as she has been complaining of tiredness, breathlessness and pains in her chest. When she arrives she is in some distress, the GP assesses her and decides she requires blood tests and refers her to the practice nurse.

The practice nurse explains the procedure to Mrs J, but Mrs J declines and seems a little agitated, therefore the practice nurse asks her if she has had bloods taken before and what her past history is. Mrs J tells her she is a bit forgetful and her husband is usually with her as he can remember better. At this the practice nurse asks if she can bring her husband in, and Mrs J agrees with some relief. Mr J is invited in, with Mrs J’s permission, and once present the practice nurse explains again the reason the doctor has asked for the blood tests. Mr J is then able to explain the tests to his wife and she is reassured. After a further discussion with the practice nurse, Mrs J now understands the reason for the tests and agrees to the blood samples being taken.

All staff working in the NHS have a duty to respect and maintain the confidentiality of patient information they process during the course of their duties.
3. Identify own professional clinical skills practice in accountability as a practitioner

Evidence-Based Practice/Knowledge
Finlay (2004) outlined the need for each practitioner to follow evidence-based practice, ensuring decisions are made on sound, current knowledge. Furthermore, Finlay (2004) argued evidence based practice is not simply research based practice, but a dynamic process, whereby the practitioner would seek out and evaluate relevant sources of knowledge. Young (2009) suggested that in terms of a practitioner discharging their clinical duty, there is an expectation that all practitioners will employ evidence based practice and interventions.

Within the NMC Code (2008):
- Members must lead by example, always demonstrating respect and dignity for others; value diversity and ensure that they conduct themselves in a non-discriminatory manner at all times.
- Members must be committed to the continuing demonstration of the competence required for the effective performance of their role on Council and on any of the Council’s committees.
- Members must complete and maintain their entry in the Council’s Register of Members’ Interests declaring any professional, personal or business interests which may, or might be perceived to, conflict with their responsibilities with Council.

As a practitioner you should compare your current knowledge against the knowledge requirements and benchmarks for that skill/aspect of practice, and then identify any gaps, based on current evidence and best practice standards. The CS MEN education packs/workbooks are crucial to support this process; however they do not replace organisational policies or other evidence based materials, e.g. Joanna Briggs Institute (JBI) manual or NHS Quality Improvement Scotland (QIS) Best Practice Statements, i.e. Ear Care (2006) or Royal Marsden Hospital Manual of Clinical Nursing Procedures.

It is essential you undertake any appropriate pre-training preparation.

Codes of Conduct
Professional bodies have developed their own codes of conduct:
GMC – Members Code of Conduct
NMC – The Code
HCPC – Standards of conduct, performance and ethics
GDC- Standards for the Dental Team

These codes give practitioners from different professional groups very clear guidance as to what is expected from them in their role whilst delivering patient care. In nursing and midwifery, the NMC constantly update and refine their code of conduct covering issues such as accountability, advocacy, duty of care and working together (NMC, 2008). The NMC Code is currently undergoing a review and the new version is expected to be available later in 2014. Revalidation is also about to start in 2015 and will ensure that nurses are fit for practice by scrutinising their CPD and ongoing learning.

The GMC have identified key requirements of doctors in Good Medical Practice (GMC, 2013). Standard expectations include a good standard of care which encompasses competence; being honest and trustworthy; respecting patients’ dignity and privacy and making patients the priority.

The Health Professionals Council has oversight of all allied health professionals and their regulatory councils to ensure quality and accountability are providing the right care to the right person at the right time and to the right standard (www.hpc-uk.org).

What professional criteria do we need to be accountable?

In order to provide a rationale for both actions and omissions, you require to be:

- Skilled
- Knowledgeable
- Competent.
Action Box 6

Consider your answers in relation to your current practice or the training education you are about to undertake.

a) What do I have to be knowledgeable?

b) What skills must I have?

c) How will I know when I am competent?

Knowledge

What YOU would need to be knowledgeable about would depend on your practice requirements, e.g. if commencing an IV medicines administration role, you would need a range of knowledge, such as medicines, infusion devices, pharmacology and calculations, etc. You would also require knowledge of policies, best practice, standards and procedures. Accountability is integral to clinical practice whatever your professional background and so it is essential to be aware what you are accountable for and to whom within your clinical practice. Once you have the appropriate knowledge, relating to your practice, you would need to consider the capability of your clinical skills.

Skills

What clinical skills would you require? Again this will depend on your role and job requirements, e.g. you have been asked to undertake venepuncture practice therefore you will need the skill to:

- assess the patient
- communicate with the patient, e.g. gain consent
- use the appropriate equipment
- safely and successfully take a sample from the patient.
Therefore, to undertake your role you will need to be competent. Many roles require specific supervision and assessment of competence, e.g. peripheral IV cannulation.

Competency also includes related skills:

- **Psychomotor skills**: the technical ability in handling equipment, e.g. monovette system for venepuncture
- **Critical thinking skills**: problem solving, decision making skills, e.g. using SEWS/SBAR to monitor patient’s condition
- **Interpersonal skills**: e.g. communication skills (CHPP, 2003), gaining consent and offering patient education.

**Competence**

Confidence, although important, should not be confused with ‘competence’. It is possible to be confident and not competent! Equally it is possible to be lacking in confidence but be very competent!

The NMC (2008) stipulated that to be competent you must “have the knowledge and skills for safe and effective practice when working without direct supervision”.

Thus the competent practitioner carries out practice to the required standard, and is able to articulate what they are doing and why they are carrying out practice in that way, being able to justify their actions or omissions without the need for any direct supervision.

The achievement of the competence process requires support and supervision, and for all clinical skills requires you to have a minimum of six supervised practices in the specific skill, e.g. bolus IV injections; followed by a final assessment of competence.

There may be competency assessments associated with the education/training course, but competency relates not only to being able to perform a skill to a certain standard, but also to being able to explain what you are doing and why you are doing it. You remain accountable for ensuring that your professional knowledge, skill and competence are maintained.

“’You must have the knowledge and skills for safe and effective practice when working without direct supervision”.

(NMC, 2008)

The Code (NMC, 2008) also promotes the principles that you work with others to protect and promote the health and well-being of those in your care, and this includes effective delegation. Many of the core medical and specialty training programmes are now competency based.
Action Box 7

Before proceeding, read your relevant professional code (ie, GMC, GDC, NMC or equivalent)

a) What systems are in place to ensure your competency in clinical skills procedures?

b) What aspects of your code of conduct can you apply to the carrying out of clinical procedural skills? NB: If you have no professional code of practice, what systems are in place to ensure your competency in relation to clinical procedural skills?

Context

In being accountable in health care practice the context in which care is being delivered becomes an integral component of the system with its norms of practice. What is expected in primary care may be different from secondary care in terms of knowledge and skills but the same standards will be expected in relation to patient safety at all times in whatever context e.g. “The Bolam Standard “.

Chaperone

In the delivery of any clinical skill and whatever your professional background you should always consider whether a chaperone is required. One of the safest approaches which protects both you and the patients is to ask if they would like someone else to be present during the procedure.
The General Medical Council has clear guidelines on chaperoning for intimate examinations and suggest that patients be offered one whether you as a practitioner are the same gender as the patient.

The GMC highlight the need to maintain the patient’s dignity and privacy. The role of communication skills is emphasized in terms of explaining to the patient the procedure or examination so they have a clear idea what to expect.

A chaperone is an impartial observer and you as the health care professional carrying out the procedure must be satisfied the chaperone will

- Be sensitive and respect the patients dignity and confidentiality
- Reassure the patient if they are distressed
- Be familiar with the procedure
- Stay for the whole examination to see what is being done
- Be prepared to raise concerns

A relative or friend is not a suitable person to be a chaperone. Please make sure you are familiar with your organisations chaperoning policy.
4. Demonstrate an understanding of legal aspects related to the professional practice of clinical skills

**Professional and Legal Aspects**

It is difficult to separate professional and legal issues in relation to carrying out clinical skills as they are so often interlinked. Professionalism is perceived as central to a practitioner’s practice. Traditionally, professionalism was defined as specialised areas of human activity which have resulted in societies bestowing high status on their practitioners. The understanding of professionalism, however, has changed with the increasing rate of alteration in legal and techno-scientific fields and in the socio-economic environment.

Health professionals must be aware of the law as it relates to them both as a professional and as an individual. It is assumed that doctors, nurses and other health care professionals know their legal position. The law often differs between Scotland, England, Northern Ireland and Wales and the health care professional must be clear about the legislative framework in the country in which they practise professionally. There are changes in relation to personal indemnity insurance and it is essential that you are aware of your own requirements.

**Child/Neonatal Considerations**

Ethical and legal issues in child health care are multifaceted. Not only are ethical dilemmas often highly emotive, but often practitioners are required to make a judgement as to whether or not a child is competent. Practitioners are also accountable and answerable for their decisions.

Ethical principles discussed in Section 2 of the pack are also applicable here. However, there are defined laws that practitioners must adhere to. Click here for GMC guidelines and here for NMC guidelines.

**The Age of Legal Capacity (Scotland) Act, 1991**

“A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedures or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedures or treatment.”

In Scotland, parents have responsibility for their child up to the age of 16 years, enabling them to give consent on their child’s behalf. Complexities arise when an older child disagrees with their parent. Under the Age of Legal Capacity (Scotland) Act, 1991, no parent, doctor or indeed court can override a competent child’s decision.
In England Gillick competence case law is used (Scarman, 1985). The Gillick case involved a girl under the age of 16 years requesting the contraceptive pill without her parent’s knowledge. Again the responsibility is on the medical practitioner to decide whether a child under the age of 16 years is ‘Gillick competent’. Lord Scarman (1985) explained:

“As a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to enable him to understand fully what is proposed.”

**Action Box 8**

A fourteen year old boy requires urinary catheterisation. Following an explanation of the procedure the child refuses to be catheterised. However, his parents wish for the procedure to be carried out.

a) Discuss the ethical and legal issues of this scenario

b) Explain what actions you would take in this scenario

**Accountability and Legal Aspects**

Practitioners are personally accountable for their actions and omissions through the law and have a legal duty of care to their patients. This duty requires, amongst other things, that a
practitioner carries out any procedure with reasonable skill and care, and informs patients of the risks of any proposed procedure or treatment (Young 2009).

**Duty of Care**

**Action Box 9**

Considering your duty of care – how would you protect yourself and your patients / clients when understanding this role / clinical skill?

For a legal action to succeed a breach of the legal duty of care would have to be established and the law would judge the practitioner by the ‘objective practitioner’ standard e.g. The Bolam standard i.e. were the actions those that could reasonably be expected from an average skilled practitioner (Tingle, 2001). The burden of proof rests with the claimant (patient / carer). However, as Young (2009) stated, in practice a defendant will need to put forward a reasonable justification for what happened. Thus practitioners must take reasonable care to avoid acts or omissions that they can reasonably foresee would be likely to injure a patient (Hyde, 2008).

In law, the courts could find a registered practitioner negligent if a patient suffers harm, because the registered practitioner failed to care for them properly. Please note, neither inexperience nor ignorance of current practice in healthcare or professional/legal issues related to healthcare is an excuse for poor care or causing harm to a patient (Finlay, 2004).

To demonstrate negligence, it would have to be proved that:

- The health care practitioner had a duty of care to the patient
• The health care practitioner failed to adhere to the standard of care and there is a breach in the duty, e.g. failed to wash hands
• As a consequence the patient suffered harm, e.g. physical, psychological or financial.

Young (2009) suggested this duty of care is linked with standards and performance in healthcare, and is central to clinical governance. Thus an organisation must have in place clinical governance systems, e.g. Health and Safety, risk reporting, education and training, and supervision processes, etc, to ensure safe quality effective care is delivered and monitored.

**Action Box 10**

What safety and governance processes are you aware of in your practice area?

**Vicarious Liability and Legal Aspects**

Cox (2010) indicated the onus here is on employers, to ensure they provide their staff with the appropriate training and supervision until they demonstrate their competence in the new role/s and can work to appropriate standards of care. It is however also the individual’s responsibility to ensure they are working within their designated duties, have received the appropriate training and are competent for the role/s, and are working to agreed policies and procedures.

Furthermore, Hyde (2008) discussed recommendations that nurses/midwives have professional indemnity insurance when advising, treating and caring for patients’. The Code
(NMC, 2008) recommended this, and further suggested this is in the interests of clients, patients and registrants in the event of claims of professional negligence.

**Capacity**

Each practitioner must be aware of the legislation regarding mental capacity; ensuring people who lack capacity remain at the centre of decision-making and are fully safeguarded (DH, 2007; NMC, 2012). The Adults with Incapacity Act (Scotland) 2000 (SE 2000) gives the following definition of incapacity:

An adult over the age of 16 incapable of:

- **Acting; or**
- **Making decisions; or**
- **Communicating decisions; or**
- **Understanding decisions; or**
- **Retaining the memory of decisions.**

For patients and clients who are not deemed to be capable of giving consent, treatment should only be undertaken in relation to the principles of The Adults with Incapacity Act (Scotland) 2000 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.

If an adult is assessed as incapable in relation to a decision about medical treatment, a Certificate of Incapacity, and potentially a treatment plan, must be completed. The consulting doctor is responsible for this, and also following appropriate discussion with the patient and their family/carers.
5. Demonstrate a professional approach to safe documentation (both written and electronic) in the context of clinical skills practice

Good Practice in Professionalism in the Digital Age

Patient Data in a Technological Age

Patient information, in the context of treating your patients, is confidential, and may not be used or disclosed for any other purpose. No patient information may be downloaded into another computer or electronic device.

No software or unauthorized material may be downloaded onto the hospital computers. You may not take photographs of patients or other visitors, except for caregiver training, and with written permission of all parties.

Mobile phone usage is not normally permitted in clinical areas or during patient treatment.

Searching the internet

Computers may be used to access the Internet for information about general medical conditions, community resources, and a wide variety of other applications.

Other large portions of the Internet have no application to your clinical work. Please do not access these sites from the hospital. Our IT systems and services are critical to our patient care and our business, and we need to make sure it is used for business and appropriate purposes.

Social Networking: e-professionalism advice

Never post information about a patient or clinical area on a social networking site. Use appropriate networking sites (e.g. Google +) for support, assessment and intervention ideas, developing collaborative or mentoring relationships, and asking general questions. Explore the use of electronic technology for professional development, join electronic article reviews/journal clubs, list-serves and other community resources. Please follow your own council guidelines on the use of social media and networking.

Documentation

Always ensure records are maintained and accurately reflect the care planned and delivered (NMC, 2009b). Hyde (2008) argued record keeping is an integral aspect of professional practice, and not an optional extra. Records are legal documents admissible in court, therefore accurate, accessible and comprehensive records are essential for effective quality care, especially when care is a shared responsibility, e.g. IV medicines administration.
One particular protocol often neglected is checking the patient’s identity wristband, and Jones (2009) cited a study where only 57% nurses stated they had checked the patient’s ID. Please refer to your NHS Patient Identification Policy.

“All inpatients, day case patients and outpatients receiving therapy and including those in the resuscitation rooms of Accident and Emergency, Combined Assessment, Acute Receiving/Assessment Units inclusive of Obstetric Triage and Admission who are undergoing assessment and investigation prior to admission MUST wear an ID Band for safety purposes unless the Nurse/Midwife in charge of the shift believes this is contrary to the patients well-being or the patient refuses to wear one”.

The accuracy of patient detail on the identity band is an essential component of the patient checking procedure.

Before proceeding with any clinical skill, wherever possible, ask the patient to tell you their full name, date of birth and/or address as appropriate and explain to the patient why you are checking this information. You must obtain consent, verbal or otherwise, and check details against the patient ID bracelet and relevant documents, e.g. prescription chart.

**Remember, the quality of record keeping is seen as a reflection of the standard of the practitioner’s professional practice (NMC, 2009b).**

The Academy of Medical Royal Colleges (AMRC) in association with the Health and Social Care Information Centre (HSCIC) brought out the expected standards for the clinical structure and content of patient records in July 2013. They highlight standards for generic headings for admission records, handover records, discharge records and referrals. These standards have been endorsed by 50 organisations that give professional leadership to the medical nursing and allied health care professions. This means that these standard headings can be incorporated into local documentation enhancing standards while ensuring local ownership ([www.rcplondon.ac.uk/](http://www.rcplondon.ac.uk/)). Please be aware of any local guidelines in place.
Section 3
Theoretical Assessment

Case Scenarios - What Can Go Wrong?
To further help you consider a range of clinical skills and accountability aspects, please select and complete the appropriate scenario/s.

Scenario 1: Venepuncture
Mrs T, had phlebotomy performed in a ward, where her blood samples were taken without any apparent problems, and a sterile plaster was applied to the site. However, a few hours later Mrs T complains of itch and slight pain at the site. The nurse advises her she will check the site later, as she is busy.

Scenario 1

a) What action should the nurse have taken when Mrs T reported the pain and itch?

b) Can the nurse defend her actions?
Scenario 2: Peripheral IV Cannulation

Mr M is an older gentleman in theatre for a coronary bypass graft, and he requires a peripheral IV cannula inserted. During the procedure he complains of tingling pain in his arm and becomes quite distressed.

Scenario 2

a) What actions would you take?

b) How could you justify your practice if Mr M complains
Scenario 3: IV medicines administration
As you are giving Miss X an IV drug, she complains of feeling unwell, saying she feels hot and sweaty.

Scenario 3

a) What action would you take in this scenario?

b) How could you offer to justify your actions?

Key Learning Point Regarding Prescriptions
Always check the prescription chart prior to administering any medication, and note you will be held to account for using the prescription. So if a medication is prescribed incorrectly and you follow the prescription and administer the medicine, you are as equally accountable as the prescriber.
Scenario 4: Infusion Devices

Mrs J is admitted to the ward for a bowel resection. On return from theatre, you note Mrs J’s anaesthetic chart has Morphine prescribed post operatively. You set up a syringe pump to administer the drug by continuous infusion. Later a support worker calls you over because Mrs J appears to be unwell.

Scenario 4

a) What action would you take?

b) There is an over-infusion, but the cause is unknown as yet. What safety processes are in place to prevent this type of incident occurring?

Discussion Point

Remember you are accountable for the setting up and maintaining of any infusion and device, that you use in the care of your patient. If you are taking over the care of a patient with an established infusion, you must always check the 5 rights, thus check it is the right patient, medication, dose, route, and time; and if using a device, check the device is functioning and positioned correctly and the rate is set and being delivered correctly.

You will be accountable for your actions or omissions, therefore ensure you confirm the device/infusion is set up correctly, and that you effectively monitor the patient and the infusion throughout the infusion and document all aspects including any actions.
Scenario 5: Immunisation

Mrs P has arrived with her nephew John (next of kin) for the ‘flu’ vaccine. Mrs P shows signs of Alzheimer’s disease, and refuses the vaccine. Her nephew is adamant; she must have the vaccine.

He becomes irritated with you as you voice concern about vaccinating his aunt against her wishes. He states he is her next of kin and is giving his verbal consent. He also states his aunt’s presence indicates her implied consent.

Scenario 5

a) What action would you take?

b) What are your concerns?
Scenario 6: Ear Irrigation

Mr S, 75 years old man has complained of increasing deafness to his GP over the past few weeks. He has been referred to you, and you assess his ears and see evidence of cerumen (wax) and confirm that his ears should be irrigated.

You commence the procedure, but Mr S complains that he feels dizzy.

Scenario 6

c) What action would you take?

d) How could you defend your actions?
## Appendix 1: Accountability and KSF

KSF Level descriptors may vary depending on individual/practice setting.

<table>
<thead>
<tr>
<th><strong>Core Dimensions</strong></th>
<th><strong>Educational elements/indicators</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>Through completion of workbook, reviews:                                                                                           Effective communication, e.g. capacity/consent.                                                                                     Communication skills and teams, e.g. delegation.                                               Recording procedures/documentation standards</td>
</tr>
<tr>
<td>Personal and people development</td>
<td>Through completing action boxes in workbook:                                                                                          Evaluates own learning needs.                                                                                                         Identifies gaps and resources to address these (NMC Code 2008).                                         Develops understanding of ‘best’ practice so can share with others.   Reviews learning against own PDP.</td>
</tr>
<tr>
<td>Health, safety and security</td>
<td>Through completing workbook, reviews:                                                                                               Risk assessment and processes to manage risks.                                                                                           Practice aspects, through scenarios, to build confidence and awareness of necessary skills.                                                                                      Reporting processes, e.g. Safety Bulletins.</td>
</tr>
<tr>
<td>Quality</td>
<td>Through completing the workbook:                                                                                                         Is aware of relevant legislation and standards.                                                                                             Is aware of the need to self monitor practice and maintain competence.</td>
</tr>
<tr>
<td>Equality, diversity and rights</td>
<td>Through completion of workbook:                                                                                                         Is aware of need to respect people’s rights and recognise their beliefs and choices.                                                                                                         Discusses patient capacity and consent issues.</td>
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<tr>
<th><strong>Specific dimensions</strong></th>
<th><strong>Skills related examples</strong></th>
</tr>
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<tbody>
<tr>
<td>HWB7 Interventions and treatments</td>
<td>Through completing workbook, understands;                                                                                               Relevant NHS policies and guidelines.                                                                                                          Key clinical skills and NHS ‘best practice’.                                                                                          Effective communication requirements re. treatment.                                                                                       How adverse events are reported, e.g. Datix</td>
</tr>
<tr>
<td>HWB9 Equipment and devices to meet health and wellbeing needs</td>
<td>Through completing workbook, discusses;                                                                                               How to follow best practice in the use of equipment.                                                                                           How to ensure competent to use equipment.</td>
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</table>
Appendix 2: Scottish Credit Qualification Framework (SCQF) and accountability

Considered at level 9 – Bachelor’s degree as expect following characteristics:

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Expected learning outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge and understanding</td>
<td>Demonstrate theory and understanding through completing workbook, analysing; The key principles of professional accountability. The arenas of accountability and their impact. Legal aspects and relation to practitioners. Professional requirements, e.g. communication / capacity / consent. Specific skills and procedures, e.g. IV medicines administration. Associated aspects, e.g. record keeping / documentation.</td>
</tr>
<tr>
<td>Practice; applied knowledge and understanding</td>
<td>Through completion of specific case scenario/s: Can review practice through the scenarios. Can review the need for evidence based practice and identify suitable sources. Can describe specific clinical skills and the implications for practice.</td>
</tr>
<tr>
<td>Generic cognitive skills</td>
<td>Through completing workbook can: Identify specific professional risks or problems and management of these, e.g. delegation. Develop problem solving and decision making skills.</td>
</tr>
<tr>
<td>Communication, ICT and numeracy skills</td>
<td>Through workbook and learning: Develop awareness of communication skills relating to clinical skills and procedures.</td>
</tr>
<tr>
<td>Autonomy, accountability and working with others</td>
<td>Through workbook and learning: Define own accountability and team working skills, e.g. effective communication, delegation. Discuss the need to practice in accord with code (NMC 2008). Is challenged to identify own knowledge and any gaps, so ensure develops into safe and competent practitioner.</td>
</tr>
</tbody>
</table>
SEWS Chart Example

Pain Assessment & Management Guidelines

- Pain Score: 0 to 10
  - 0: Pain Free
  - 1 to 3: Mild Pain
  - 4 to 6: Moderate Pain
  - 7 to 10: Severe Pain

Guidelines

- CQG: (Chart Observer’s Go-to Quiz) Check Observer’s Quiz
  - Yes: Complete the quiz
  - No: Continue with assessment

- Pain: 0 to 10
  - Pain Free: No Pain
  - Mild Pain: 1 to 3
  - Moderate Pain: 4 to 6
  - Severe Pain: 7 to 10

- Pain Management: (Chart Observer’s Go-to Quiz) Check Observer’s Quiz
  - Yes: Complete the quiz
  - No: Continue with assessment

Measuring Sedation

- The SEWS system uses the ASHS scoring system for conscious level. ASHS is an acronym for Alert, Sleep, Unresponsive, Dormant, and Severely Hypnotized.
- The ASHS scoring system ranges from 1 to 5, with higher scores indicating increasing levels of consciousness.

Measuring Nausea

- Nausea: 0 to 3
  - 0: No Nausea
  - 1: Mild Nausea
  - 2: Moderate Nausea
  - 3: Severe Nausea

Additional Observations

- Vital Signs
- Respiratory Rate
- Temperature
- Blood Pressure
- Oxygen Saturation
- Other relevant observations

Further SEWS Score Should Be Checked

- In the event of a sudden worsening of change
- If there is a concerning factor
- If the patient’s condition worsens

Date of Observation

- Date: (Month/Day/Year)

For further information, see SEWS Chart Example, page 41.
Resources and References


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General Medical Council (2006) Raising concerns about patient safety www.gmc-uk.org/guidance


General Medical Council (2014) Education and Training Accessed 10/06/14 www.gmc-uk.org/education


NMC (2009b) Record keeping: Guidance for nurses and midwives. NMC: London


Rodgers R (2009) Safe Ear care; informal advice and safe practice, Practice Nursing 20 (2) pp93-96

Scarman (1985) Gillick v West Norfolk and Wisbech Area Health Authority 3 All ER 402 (HL).


References: per Skills Aspect

Ear Irrigation
NHS Quality Improvement Scotland (2006) Ear Care; Best Practice Statement, NHS Quality Improvement Scotland: Edinburgh

Venepuncture


**Peripheral IV Cannulation**

Rosenthal K (2005) Tailor your I.V. insertion techniques special populations Nursing 35 (5) pp36-41

**Immunisation**
Department of Health (2006) Immunisation against infectious diseases (Green Book) at www.dh.gov.uk/greenbook

**IV medicines administration**


**Patient Safety**

Reducing harm from omitted and delayed medicines in hospital. NPSA; London

**Further Reading**


General Medical Council and Medical Schools Council. Medical Students: Professional Values and Fitness to Practise. 2009.


Health Professions Council (2008) Standards of conduct, performance and ethics, HPC: London


NHS Lothian (2009) Policy on Confidentiality of Personal Health Information, NHS Lothian; Edinburgh


NHS Lothian (2009) Policy on Confidentiality of Personal Health Information, NHS Lothian; Edinburgh


Spector ND, Matz PS, Levine LJ, Gargiulo KA, McDonald MB 3rd, McGregor RS (2010) e-
http://www.tourolaw.edu/cso/docs/eprofessionalism.pdf

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This resource has been adapted from NHS Lothian Accountability workbook and NHS
Tayside, NHS Fife and University of Dundee workbook on Professionalism.

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Date developed: November 2004

Last review date: May 2014   Next review date: May 2016

Please remember to evaluate this study guide by clicking here. It should only take a few
minutes to complete.
RECORD OF COMPLETION OF PROGRAMME

(Professionalism and Professional Accountability in Clinical Skills Practice)
This record must be completed by all practitioners completing this clinical skills programme. Their assessor should sign below on satisfactory completion of the study guide and a copy should be retained each by the practitioner and their manager.

PRINT Full Name:

Profession (please circle one): NURSING & MIDWIFERY / MEDICINE / AHP

Job Title: Clinical Area:

Directorate (if applicable):

Hospital / primary care facility:

Name of Assessor:

<table>
<thead>
<tr>
<th></th>
<th>Signature (Practitioner)</th>
<th>Signature (Assessor)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of theoretical assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to demonstrate the relevant knowledge of professional issues and an understanding of health care ethics in the delivery of procedural clinical skills</td>
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Address for certificate to be sent: