

# Part I

## Professional Values

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# 1

## The Code of Conduct and Professional Practice

### Aims and objectives

The aim of this chapter is to enable the reader to begin to understand some of the key professional values that underpin the art and science of nursing.

At the end of the chapter you will be able to do the following:

- Discuss some of the professional attributes that underlie the art and science of nursing
- Demonstrate an understanding of the history of nursing and the historical landmarks
- Outline the key functions of the Nursing and Midwifery Council
- Describe the key issues associated with codes of professional conduct
- Begin to apply the concepts discussed to the practice setting
- Appreciate the Nursing and Midwifery Council's requirements of student nurses

The fundamental basis of nursing is associated with caring and helping; nursing is both an art and a science. One key aspect of the nurse's role is to help people achieve or carry out those activities of living that they are unable to do for themselves. There are many facets associated with the role and function of the nurse. It is a fluid and dynamic entity and this makes it difficult to define.

There are a number of definitions of nursing. One is that of Henderson, which has been used since the 1960s:

*The unique function of the nurse is to assist the individual, sick or well, in performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge and to do this in such a way as to help him gain independence as rapidly as possible. (Henderson, 1966)*

This definition is succinct and to the point. It attempts to encompass and encapsulate many of the roles that the nurse performs, such as carer and health educator. Such a definition could be seen, although not exclusively, as the nature of nursing. Another definition provided by the Royal College of Nursing (RCN) is:

*The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability until death. (RCN, 2003)*

This chapter is concerned with professional values that underpin nursing practice. An overview of the development of nursing, from what was an unstructured, *ad hoc* approach to caring, to what has become a regulated profession, is provided. The student nurse and unregistered practitioners are not subjected to the rigours of professional regulation. However, when you successfully complete your programme of study leading to registration, you will be subject to professional accountability and all that it entails (NMC, 2010a). It is expected that the student nurse will commit to the values of the profession and that he or she accepts and internalises the Code of Conduct as part of the process leading to registration. The code of professional conduct, performance and ethics for nurses and midwives is discussed in detail in this chapter, with emphasis on commitment to the principle that the primary purpose of the registered nurse is to protect and serve society.

## A brief overview of the history of nursing in the UK

This brief overview of how the practice of nursing has evolved over the years outlines some key stages in the development of the nursing profession from a British perspective. It must be remembered, however, that the evolution of nursing in the UK did not occur in a vacuum. There are several other international factors that have also helped to focus and shape where we are today and where we may be going tomorrow.

To understand contemporary nursing it is important to have an understanding of where nursing has come from, how nursing has emerged and how it continues to evolve (Craig, 2010). Having an understanding of the way nursing has evolved and developed over the years may help you to appreciate the following:

- Why nursing is regarded as a profession in its own right
- How, by becoming empowered, nurses are in a position to enable others to do things for themselves
- That nurses have become autonomous practitioners
- How nurses are called to account for their actions and omissions.

This aspect of the chapter makes use of a 'time line' in order to frame the discussion about the historical overview. A time line provides you with important dates and events that have occurred over the years and that have had an influence on the evolution of the nursing profession. The discussion centres on the significant events and key characters that have influenced the development of nursing over the ages.

### The prehistoric era

The practice of nursing predates history, according to Craig (2010). Those who lived in the prehistoric period suffered similar conditions to those experienced by society today. Tribes in those early years took part in caring for their sick and wounded (Hallett, 2010). Archaeologists have retrieved human remains that demonstrate that fractured limbs have been healed, suggesting therefore that some form of care provision occurred. Healers or shamans used various potions and magical concoctions to heal the sick. Those responsible for feeding and cleaning the sick were predominantly females.

The Bible makes reference to nurses and midwives, e.g. *Genesis* 35 and *Exodus* 1. In *Exodus* 2 there is evidence to suggest that nurses were paid for their services. *Numbers* 11 refers to males who undertook the caring role.

## The ancient Greeks

In ancient Greece temples were erected to honour the goddess Hygeia, the goddess of health. Care at the temples was related to bathing and this activity was overseen by priestesses, who were not nurses. The foundation of modern medicine was laid down by Hippocrates during this period. Navel cutters – known as *omphalotomai* – were also practising at this time.

## The Roman Empire

The first hospitals were established in the Byzantine Empire, which was the first part of the Roman Empire. As the Roman Empire expanded hospitals were erected. It was Fabiola, a wealthy Roman, who was responsible for the introduction of hospitals in the west; she devoted her life to the sick and made nursing the sick and poor fashionable in Roman society. The primary carers in these hospitals were men, who were called *contubernails*. After the Roman invasion in approximately AD 2 slave girls were known to assist Roman physicians. *Valetudinaria* – civilian hospitals – were kept clean and aired by bailiffs' wives, who would also watch over the sick.

## The Middle Ages

Throughout the Middle Ages military, religious and lay orders of men provided most of the health care. Some of these orders of men included the Knights Hospitalers, the Order of the Holy Spirit and Teutonic Knights. Although these men provided care, charlatans and quacks provided treatment for money. The standard of care provided by the latter people often did more harm than good.

Several hospitals were opened during this period, e.g. St Thomas's, St Bartholomew's and Bethlem. Care provision that had been provided by nuns was now provided by local women, whose efforts were overseen by matrons. Their duties centred on domestic chores.

## The Enlightenment

The core period of the Enlightenment was the second half of the eighteenth century. Scientific endeavour flourished during the Enlightenment and philanthropists provided the means to open charity hospitals around the UK. In London, for example, the London, Middlesex and Guy's Hospitals provided care to the poor who were ill. These hospitals employed nurses who may have been paid or unpaid. These nurses again predominantly carried out domestic duties. Pay was low and it was not unusual for nurses to drink alcohol and take money from patients in order to pay for their alcohol. Nurses at this time were slovenly and lazy, and reflected characters such as Sairey Gamp and Betsy Prig, caricatures devised by Charles Dickens. Alms houses depended on women to clean floors, make beds and bathe the poor. There were no standards for nurses to work towards.

Medical schools began to emerge as medical knowledge grew. The Royal College of Surgeons was formed in 1800 and at this time doctors were required to carry out some aspects of their training in hospitals.

## Florence Nightingale

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The founder of modern nursing was born in Italy in 1820 and died aged 90 in 1910. When she was 25 years old she told her parents that she wanted to become a nurse. Her parents were totally opposed to the idea, because nursing was associated with working-class women and had historical links to domestic service and vocational work.

In March 1853, Russia invaded Turkey, and Britain, concerned about the growing power of Russia, went to Turkey's aid. This conflict occurred in and around Scutari and became known as the Crimean War. Soon after British soldiers arrived in Turkey, they began to fall ill with malaria and cholera. Florence Nightingale volunteered her services to the war effort and was given permission to take a group of nurses to a hospital in Scutari based several miles from the front.

Mary Seacole, a Jamaican woman with much expertise in dealing with and caring for those with cholera, arrived in Scutari to offer her services to Nightingale, but these were refused. Undeterred, Seacole set up her own services and provided these to the British and Russian soldiers, often at the battle front (Anionwu, 2005).

In 1856 Florence Nightingale returned to England as a national heroine. She set about reforming conditions in British hospitals (in the first instance this was confined to military hospitals). She published two books, *Notes on Hospital* (Nightingale, 1859a) and *Notes on Nursing* (Nightingale, 1859b). Nightingale was able to raise funds to improve the quality of nursing. In 1860, she used these funds to found the Nightingale School and Home for Nurses at St Thomas's Hospital. She also became involved in the training of nurses for employment in the workhouses.

Nightingale acknowledged the influence of the environment on health. She suggested the environment should be one that promotes health and campaigned for wards to be clean, well ventilated and well lit. She believed that:

- there should be a theoretical basis for nursing practice
- nurses should be formally educated
- a systematic approach to the assessment of patients should be developed
- an individual approach to care provision based on individual patient needs was required
- patient confidentiality needed to be maintained.

Nightingale, together with the philanthropist William Rathbone, set up the first district nursing service in 1861. Queen Victoria gave her support to this venture and district nurses became Queen's Nurses. Caring for the well person was a concept that Nightingale wanted to see developed, and in the late 1800s her thoughts came to fruition when courses were provided to teach women to develop an insight into sanitation in homes. These women, who had a duty to care for the health of adults, children and pregnant women (pre- and antenatal), could be seen as the first health visitors. In 1873 Nightingale wrote: 'Nursing is most truly said to be a high calling, an honourable calling.' She died in London in 1910.

## Towards registration

Throughout the 1890s pressure grew for the registration of nurses. In 1887, Ethel Bedford-Fenwick formed the British Nurses' Association, which sought to provide for the registration of British nurses based on the same terms as physicians and surgeons, as evidence of their having received systematic training. Bedford-Fenwick was a staunch supporter of professional regulation. Up until this time nurses remained relatively free from external regulation. In 1902, the Midwives Registration Act established the state regulation of midwives; this Act came about as a response to the concerns about the rising numbers

of deaths of women in childbirth (Davies and Beach, 2000). A House of Commons Select Committee was established in 1904 to consider the registration of nurses.

The First World War (1914–18) provided the final stimulus to the creation of nursing regulation, partly because of the contributions made by nurses to the war effort. The College of Nursing (this became the Royal College of Nursing in 1928) was established in 1916.

Eventually, in 1919, the Nurses Registration Acts were passed for England, Wales, Scotland and Ireland. The General Nursing Council (GNC) for England, Wales, Scotland and Ireland and other bodies were established as a result of these Acts. The Councils were established in 1921 with clearly agreed duties and responsibilities for the training, examination and registration of nurses, and the approval of training schools for the purpose of maintaining a Register of Nurses for England and Wales, Scotland and Ireland. The GNC had powers to undertake disciplinary procedures and remove the name of a nurse from the register if she was deemed to have committed an act of misconduct or 'otherwise' – conduct unbecoming of a nurse. The Register of Nurses was first published in 1922. The GNC and the other bodies survived intact until changes were made in 1979. These resulted in the creation of the United Kingdom Central Council (UKCC) and the four national boards.

## The establishment of a National Health Service

The National Health Service was established on 5 July 1948. The 1949 Nurses Act allowed that the constitution of the GNC be amended; the general and male nurse parts of the Register were amalgamated.

## The Briggs Committee

The Briggs Committee, a working group, was set up in 1976 to review the training of nurses and midwives. The work of this committee led to the Nurses, Midwives and Health Visitors Act 1979, which dissolved the GNC. The GNC was replaced by the UKCC for Nursing, Midwifery and Health Visiting, with four national boards for England, Wales, Scotland and Northern Ireland.

## Project 2000

Much of the work of Briggs in the 1970s paved the way for reform in relation to nurse education. In 1984 the UKCC set up a project to consider reforming nurse education, which became known as Project 2000. The UKCC's report, published in 1986 (UKCC, 1986) provided the Council's strategy. The strategy was implemented by the mid-1990s.

## The Peach Report

The Peach Report was published in response to the UKCC's desire to conduct a detailed examination of the effectiveness of preregistration nurse education and to determine if students were 'fit for practice' and 'fit for purpose' (UKCC, 1999). The report outlined several recommendations, e.g.:

- A reduction in the common foundation programme from 18 months to 1 year
- An increase in the branch programme from 18 months to 2 years

- To ensure that students experienced at least 3 months' supervised clinical practice towards the end of the programme
- Longer student placements
- The introduction of practice skills and clinical placements early on in the common foundation programme
- Greater flexibility in entry to nursing programmes.

## Contemporary nursing practice

Contemporary nursing practice is based on a sound, up-to-date knowledge base, with nurses applying the appropriate skills and attitudes when delivering nursing care. It was Nightingale who suggested that nursing was subordinate to medicine. However, this notion of the nurse as handmaiden to the doctor is changing and the various roles and functions undertaken by the nurse are testimony to this (McGann et al, 2009).

After the number of nurses became substantial and the essential nature of nursing was established in the UK, the need to regulate the practice of nursing under law grew evident. These laws are aimed at the protection of the public.

## Nursing as a profession

### Professionalism

The term 'professional' is used in many aspects of our society, and often its meaning is taken for granted. When the term 'professional' is used it refers to a process that contains some gravitas, in which a group or individual works in a knowledgeable manner and with understanding. The word professional has other meanings in other contexts. A profession is defined and measured by using several sets of criteria and characteristics.

Etzioni (1969) considered occupations such as nursing, teaching and social work as semi-professional. Nursing, he suggested, was a semi-professional occupation due to the inadequate length of time for training and because of the lack of autonomy and responsibility for decision-making. There has to be a high level of accountability and autonomy in order for an act to be professionally justified (Williamson et al, 2010; Carvalho et al, 2011).

Salvage (2003) states that the nursing profession has often held an uncomfortable social space, because it tends to lie between being a 'true' and being a 'semi'-profession. She described the 'true' professions as male dominated, elitist and powerful, e.g. medicine and law, in contrast to proletarian occupations such as domestic work, health-care assistance and unpaid women's work in the home. However, new professions are emerging and they fit the changing circumstances in which society operates today (Salvage, 2002).

## Think



What makes a profession? Many people claim to belong to professions or they say that they are professional. Can you make a list of professionals?

In your list you might have included some of the more obvious professions:

- Clergy
- Doctors
- Solicitors
- Barristers
- Physiotherapists.

But what about others who also profess to be professionals?

- Footballers
- Plumbers
- Teachers
- Engineers
- Architects
- Librarians
- Carpenters.

The terms 'professions' and 'professional' are dynamic and fluid, changing as time passes and technology changes. Burnard and Chapman (2003) state that to be professional the occupation requires a degree of skill and/or specialist knowledge. Knowledge is gained through education and the sharing and development of that knowledge with others.

The characteristics of a profession have changed over time. There are a number of characteristics that may be associated with a profession which are presented in Table 1.1.

## New nursing – new ways of working

The role and function of the nurse have changed and developed over the years. The first part of this chapter has demonstrated some of the transformations and the influences causing them. To meet the

**Table 1.1** Some characteristics associated with a profession

- Its practice is based on a recognised body of learning
- It establishes an independent body for the collective pursuit of aims and objectives related to these criteria
- Admission to corporate membership is based on strict standards of competence attested by examination and assessed experience
- It recognises that its practice must be for the benefit of the public before the profession
- It recognises its responsibility to advance and extend the body of learning on which it is based
- It recognises its responsibility to concern itself with facilities, methods and provision for educating and training future entrants, and for enhancing the knowledge of present practitioners
- It recognises the need for members to conform to high standards of ethics and professional conduct set out in a published code with appropriate disciplinary procedures
- Its knowledge base is up to date
- Successful completion of recognised programme of study permits entry on to a professional register

Source: adapted from Pyne (1998); Carvalho et al (2011).

health-care needs of the nation, political and professional pressures have transformed the role of the nurse and other health-care professionals involved in the provision of health care, with the aim of developing their full potential. As a result, nursing has seen the creation of a number of new clinical roles, e.g.:

- Family health nurses
- Nurse endoscopists
- Consultant nurses
- Nutritional support nurses
- Nurse prescribers
- Nurse practitioners
- Advanced nurse practitioners.

As society changes, coupled with rapid and important advances in science and technology, so too does the role and function of the nurse and other health- and social care practitioners. Nurses show advances in their skills and practice underpinned by an evidence base and further education.

Hospital at Night is a model of care that has been developed to efficiently and safely deliver care at night and out of hours within the requirements of the Working Time Directive (WTD). It is also a project that supports productivity and efficiency by bringing roles together to ensure a fit-for-purpose multi-professional team (Department of Health or DH, 2006a). Cameron and Masterson (2003) consider the role of the nurse at night and how the traditional role of night sister has changed considerably to become night nurse practitioner. The Hospital at Night project was a project run under the auspices of the Department of Health, aiming to redefine how medical cover is provided in hospitals during the night. The project required a move from cover requirements, defined by professional demarcation, to cover defined by competency – the night nurse practitioner is a competent practitioner. The project advocates that other staff, e.g. nurses, take on some of the work traditionally carried out by junior doctors.

## Top tips



Working at night is different to working during the day for a number of reasons and the following are issues that impact on care delivered at night:

- Professional and silo team working
- Sickest patients referred to most junior trainees
- Minimal supervision
- Minimal skill sets and competences
- Staffing levels.

Many of the new nursing roles may not have existed today if the nursing profession had not, over the years, sought to advance its professional practice and status. The key issues of clinical competence, clinical decision-making, and being aware of boundaries and limitations are central to the safety of the patient and the success of such roles.

Hood (2010) suggests that the professional nurse has three intellectual properties:

1. A body of knowledge on which professional practice is based
2. A specialised education to transmit this body of knowledge to others
3. The ability to use the knowledge in critical and creative thinking.

## Body of knowledge

Much of the work that nurses carry out on a daily basis has a theoretical underpinning. However, nurses do not always articulate this theoretical basis from which they practise (Burnard and Chapman, 2003). Often the theories cited in Table 1.2, emerging from various disciplines and scientific perspectives, allow nurses to practise effectively and, above all, safely.

The examples cited in Table 1.2 are theoretical examples reflecting a scientific perspective. Limiting caring to the scientific approach and neglecting experience could be detrimental to the care that you provide to people. Professional nursing practice is also based on a body of knowledge that is derived from experience – expertise. The combination of knowledge related to science and experience has the potential to enable the nurse to make reliable clinical decisions.

The use of expertise should never be undervalued, however; having experience may not always be enough to help provide safe care. Nurses derive knowledge through:

- intuition
- tradition
- experience.

Benner (1984) discusses the subject of intuition as a form of expertise. Intuition can be described as just knowing which comes from the individual. It is internal and can occur independently of experience or reason. It can become validated by experience and interaction with other nurses. Kozier et al (2008) suggest that intuition is also described as a sixth sense, a hunch, instinct or feeling of suspicion.

Consider the patient scenario that follows and then list the knowledge bases needed to care effectively for this patient.

### Case study 1.1



Mary Samonds, aged 86 years, has had a stroke (cerebrovascular accident). Mrs Samonds is unconscious and totally dependent on the nursing staff for all her care. When providing care for Mary with a registered nurse you find that she is incontinent of urine and faeces, so both you and the staff nurse are going to attend to her hygiene needs. Mary's husband is outside waiting for you to finish. He is clearly upset and seems distressed.

For you to care safely and effectively for Mrs Samonds and to meet all of her needs, she will require much skilled care and you will need to draw on many bodies of knowledge to do this. There are several bodies of knowledge that you could use and these will also include that important perspective – experience or expert practice. Table 1.3 lists some of the things that you might include.

## Transmitting the body of knowledge to others

Transmitting the body of knowledge to others occurs at many levels. The educational programmes of study and the educational institutions where they take place are subject to statutory approval and scrutiny. This approval is through the NMC (see below). It is the members of the profession, therefore, who validate the programmes of study that will ultimately lead to registration. Registration conveys a message to the public that the nurse who is admitted to the register has reached and possesses a satisfactory level of competence along with a certain standard of behaviour – good character and good health.

**Table 1.2** Theoretical perspectives gained from other disciplines that are used when caring for the patient

Theory basis	Example
Microbiology	Practices associated with aseptic nursing and infection control
Thermodynamics	Performance of duties associated with temperature taking and the care of the patient with a pyrexia or those who may have hypothermia
Psychology	The application of psychological theories when caring for a bereaved relative, or the importance of play in hospitalised children
Pharmacokinetics	Understanding drug therapies and how drugs are metabolised in the body
Physiology	Applying physiological theories to interpretation of nursing observations, for example physiological changes that occur if the patient has diabetes mellitus or a head injury
Sociology	Helping you to understand the patient's needs from a sociological perspective, for example understanding and addressing health inequalities

Source: adapted from Burnard and Chapman (2003); Hood (2010).

**Table 1.3** The various bodies of knowledge drawn on to care for a person

Expertise  
 Psychology  
 Sociology  
 Microbiology  
 Thermodynamics  
 Physiology  
 Pharmacokinetics

## Using that body of knowledge in critical and creative thinking

Either nurses use their body of knowledge to provide people with care that has undergone critical scrutiny, or a systematic approach has been used to provide that care. Care becomes creative and innovative and provides nurses with new ways of thinking and addressing the problems that people may have.

Advancing nursing practice ensures that nurses have the knowledge base and practical skills to provide specialist nursing care. Critical thinking allows nurses to see different approaches to clinical situations. Critical thinking occurs when nurses are faced with people who have complex needs; the situation provides opportunities for nurses to develop and plan individual care.

## Professional nursing

The Hippocratic oath laid down the moral code of conduct for the practice of medicine and the underpinning principle of this code, similar to the underpinning principle of any health-care code, is to treat the patient at all times as you would wish others to treat you.

People receiving the service of nurses must be able to trust nurses with their wellbeing. To justify that trust the nursing profession has a duty to maintain a good standard of practice and care, and to show respect for human life.

Professional nursing practice is judged not only by the recipient of care – the patient – but also by the profession itself. Professionals judge other professionals with regard to the quality and appropriateness of care provided. There are many ways in which this judgement can occur, one way being through the NMC. Deviation from the acceptable standards of practice may result in a nurse's name being removed from the professional register, ultimately resulting in removal of a nurse's licence to practise.

## The Nursing and Midwifery Council

In 1998 the government initiated a fundamental review of how the profession was regulated. The outcome of this review resulted in consultation with nurses and midwives regarding professional regulation and areas that needed to be addressed. Recommendations were suggested and acted on with regard to self-professional regulation, regulatory mechanisms and procedural rules. The UKCC and the four national boards were abolished; quality assurance elements were incorporated into the work of the NMC.

The NMC was set up by Parliament to safeguard the public and to ensure that nurses and midwives provide high standards of care to their patients. The Nursing and Midwifery Order 2001 (SI 2002/253) established the Council and it came into being on 1 April 2002. Protection of the public is the key concern of the NMC. Its duties to society are to serve and protect, and this is done as follows:

- Maintaining a register listing all nurses and midwives
- Setting standards and guidelines for nursing and midwifery education, practice and conduct
- Providing advice for registrants on professional standards
- Ensuring quality assurance related to nursing and midwifery education
- Setting standards and providing guidance for local supervising authorities for midwives
- Considering allegations of misconduct or unfitness to practise due to ill health.

The NMC maintains a register of nurses and midwives, setting standards for education and practice and offering guidance and advice to the professions. An overarching aim is to inspire confidence by ensuring that those on the professional register are fit to practise and by dealing speedily and fairly with those who are not.

The Council for Healthcare Regulatory Excellence (CHRE) promotes the health, safety and wellbeing of patients and other members of the public in the regulation of health professionals and has the job of scrutinising the work of the nine health profession regulators:

- General Chiropractic Council
- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Health Professions Council
- Nursing and Midwifery Council
- Pharmaceutical Society of Northern Ireland.

**Table 1.4** The three parts of the professional register

Nurse's part
Midwives' part
Specialist community public health nurses' part

Under the NHS Reforms and Health Care Professions Act 2002 and the Health and Social Care Act 2008, the CHRE have a number of powers, e.g. they carry out checks on how health-care regulators carry out their work as well as providing advice to the regulators about policy.

## The professional register

The NMC maintains a register of over 650 000 qualified nurses and midwives (NMC, 2011a). The nurses' and midwives' names are held on a computer database, including personal details, educational qualifications and registration status. Personal details are never released by the NMC. All nurses and midwives who wish to practise in the UK must be on the NMC register.

The NMC's registration process enables nurses and midwives to be entered on to one or more parts of the register when they have completed an approved programme of study. The registration process begins from the day the student nurse starts a course, be it for initial registration or return to practice. The approved educational institution must ensure that accurate records of a student's progression throughout the course are maintained; this is often known as a transcript of training. There are three parts of the professional register (Table 1.4).

Admittance to the professional register provides the nurse with the privilege of performing certain activities with the public that might otherwise (outside the professional relationship) be deemed unlawful. Members of the public have access to the professional register and can verify whether a nurse is registered with the NMC.

## Registration – good health and good character

Amended guidance has been issued for approved education institutions (AEIs) by the NMC concerning good health and good character (NMC, 2010a), with the aim of ensuring consistency in applying the NMC's requirements. The amendments have also been made to ensure that AEIs and the NMC are compliant with current law, e.g. the Equality Act 2010; among other things this legislation protects people who may have a disability or health condition from unlawful discrimination. The NMC state that they do not discriminate against people with disabilities by having a 'blanket ban' on particular impairments or health conditions (NMC, 2010a).

On completion of the approved programme of study, personal details of the applicant and the programme undertaken are transferred to the NMC. The AEI is obliged to make a declaration of good health and good character in support of the applicant. All practitioners must demonstrate that their health and character are appropriate to allow them to register and stay on the register in order to practise. The good health and good character elements of getting on to and renewing an entry on the register are laid down in the legislation. The requirement of good character and good health was introduced by Parliament to enhance the protection of the public after a number of high-profile cases concerning the health and character of nurses and doctors came to light in the past. The nurse must ensure that his or her

good character and good health remain just that, 'good', throughout his or her period of time on the professional register. The applicant then pays a registration fee.

Having satisfied the criteria for admission to the professional register, so that the nurse can remain on it (on the 'live' register) he or she needs to abide by the tenets stated within the code of professional conduct. To stay on the professional register, the nurse must renew registration every 3 years – known as periodic renewal. An annual fee is also required at the end of the first and second year of the registration period – the annual retention fee.

Nurses must be able to demonstrate that their skills and knowledge are suitable for their work. Currently, a nurse is required to undertake a minimum of 35 hours of learning relevant to practice over a 3-year period (Webb, 2011). The NMC, along with all the health-care regulators, are exploring the issue of revalidation in response to the Government White Paper on regulation, *Trust, Assurance and Safety: The regulation of healthcare professionals in the 21st century* (DH, 2007). The CHRE are involved in helping to support the regulators with this aspect of their legal duty.

Notification of practice must be made to the NMC and a declaration made that the nurse has met his or her post-registration education and practice (PREP) requirements for continuing professional development (NMC, 2008). He or she must also provide the annual retention fee. The issues of PREP and continuing professional development are considered in more detail in Chapter 14.

Each individual whose name is entered on the register is issued with a unique personal identification number (PIN) in card format and the date on which the registration expires. It must be noted that anyone who is newly qualified and has not yet been registered is unable to practise as a registered nurse until the registration becomes effective. It is a criminal offence for anyone to falsely and deliberately represent him- or herself as a registered nurse. The newly qualified nurse should note that the entire registration process may take up to 3 weeks from the programme completion date. It is important to apply to register within 5 years of the course completion date.

## Contemporary nursing

There are a number of key drivers and health- and social care policy initiatives that have and will continue to drive contemporary nursing practice. Issues that must be given serious consideration include changes in demographics and population growth.

### Policy

With regard to the demand for health care, the kind and main causes of disease will change. Obesity levels or health inequalities are important factors that must be taken into account. There is a continued need to support the self-care of the growing numbers of people who experience long-term health conditions. The continuing demand to meet health needs remains high, as well as patient demand for choice – on sources of advice, care packages and treatment options as well as access to care provision. The provision of care sees continued growth and an increasingly diverse role for the Third Sector, as well as reliance on the commercial sector to make available considerable inputs for secondary care provision (Longley et al, 2007). Benefits from improved information technology are felt by practitioners and patients; they bring with them information for patients, about patients, and about effectiveness and health-care performance. The increase in understanding of the genetic basis of some diseases continues to grow and develop. In some areas there is growing use of telecare to provide support to those who require care at home, with an increased understanding and use of new applications associated with

biotechnology, bioengineering and robotics. Government policy continues to concentrate on measuring effectiveness, ensuring value for money, reducing disparity in performance (locally and nationally, individually and corporately), improving safety and quality, enhancing productivity, and engaging clinicians and recipients of care in all of these aspects. NHS managerial structures are changing and this will continue, as well as provision closer to home of more generalist services and consideration given to specialist services. Regulation of the professions continues to come under scrutiny and focuses on quality and safety.

The current Government has proposed new ways of working in the form of two influential White Papers – *Equity and Excellence: Liberating the NHS* (DH, 2010a) and *Healthy Lives, Healthy People: Our strategy for public health in England* (DH, 2010b). The former sets out the Government's long-term vision for the future of the NHS. The vision builds on the core values and principles of the NHS – a comprehensive service, available to all, free at the point of use, based on need, not ability to pay. The latter provides the Government's long-term vision for the future of public health in England. The aim is to create a 'wellness' service (Public Health England) and to strengthen both national and local leadership.

## Nursing workforce

There are future potential workforce difficulties in nursing as a result of an ageing workforce coupled with financial difficulties affecting the commissioning of nurse education. Recruitment and retention continue to have a high profile to ensure that the right type of applicant is attracted to the profession and once in the profession stays; this involves reconsideration of emerging roles and responsibilities for nurses responding to health-care demands which will be dictated by flexibility in the future nursing workforce. There is an increase in specialist and advanced roles and with this comes a blurring of professional and sector boundaries (i.e. health- and social care sectors). Care provision increasingly follow the patient pathway, with an emphasis on community care, closer to home, and multidisciplinary team working. Nurses are enhancing their role in directing and leading care, and are being encouraged to adopt a more entrepreneurial outlook.

## Provision of nurse education

As health care changes so too does the role of the nurse, and so must the education required to prepare the student for the new roles and responsibilities (Carvalho et al, 2011). The NMC have introduced (after much consultation) new standards for nurse education (NMC, 2010b); students must meet these standards to be eligible to enter the professional register and the standards help to ensure parity throughout the UK for any field of nursing (fields replace branches). The appropriateness of the four nursing branches has been examined with the concern that future health services may require a more generic worker who is helpful when meeting general health needs. The provision of degree-level programmes has the potential to enhance the status of nursing even further, providing nurses with the skills needed that go beyond diploma level to ensure that the care of the patient is improved and enhanced. These standards replace the NMC's 2004 standards (NMC, 2004). The new standards have been aligned with European Union Directive 2005/36/EC *Recognition of Professional Qualifications*. This sets out the requirements for training nurses responsible for general care and provides the baseline for general nursing in the EU. The Directive includes detailed requirements on programme length, content and ratio of theory to practice, as well as the nature of practice learning and range of experience.

## Top tips



Changes occur and will continue to occur that have an impact on the way that nurses work and the career trajectories that they choose:

- Roles and responsibilities of nurses are changing
- The number of people aged over 85 years is projected to rise by almost 75 per cent by 2025
- Over 15 million people in the UK currently have a long-term condition; as the number of older people is projected to increase across the UK by between 18 and 23 per cent, so this number will increase
- Obesity rates have doubled in the last 10 years and will potentially lead to a rise in strokes, heart attacks and type 2 diabetes
- Infant mortality rates vary from 1.6 per 1000 live births in affluent areas to 9.8 per 1000 live births in less affluent areas
- Smoking is still the single greatest cause of illness and premature death in the UK, killing at least 86 500 people per year and accounting for a third of all cancers and a seventh of all cardiovascular disease

Source: adapted from DH (2006b).

## Modernising nursing careers

In 2006 the four Chief Nursing Officers of the UK established the modernising nursing careers initiative and produced a report (DH, 2006b). It forms part of an overarching programme of work covering all the main health-care professionals, setting the direction for modernising nursing careers. The priorities focus on the careers of registered nurses, recognising that nurses do not work in isolation and nursing teams are made up of more than registered nurses. Nursing careers also need to take account of changes in the careers of other professional groups. The report recognises that careers take different forms: some nurses will choose to climb an upward ladder of increasing responsibility and higher rewards, but many others opt for a more lateral career journey, moving within and between care groups and settings.

The modernisation of nursing careers brings with it the opportunity for nurses to take on new and enhanced roles and responsibilities. By undertaking these new roles nursing will be instrumental in delivering the improvements in patient care that are needed to provide a world class health service. Nurses already play a significant part in reducing waiting times, making services more accessible and improving the quality of care.

A career structure is required that will allow nurses to work in different care settings, to take on changed roles and responsibilities, develop a varied mix of skills, pursue education and training when they need it, and develop both generalist and specialist skills as they require them (DH, 2006b).

## Provision of services

Various aspects of care are offered and provided by the NHS; however, it must be remembered that it is not just the NHS that provides care – the independent and voluntary sector also provide care and services to people.

There are over 1.3 million staff in the NHS, over 80 per cent of whom are front-line staff. Of these, 60 per cent (675 000) are professionally qualified clinical staff, e.g. 126 000 doctors and 398 000 qualified nurses. They are supported by 454 000 staff in trusts and GP practices. The remainder (209 000) are NHS infrastructure support staff, with almost a half (102 000) of them in central functions, just over a third (71 000) in hotel, property and estates, and just under a fifth (37 000) as managers (NHS Information Centre, 2011).

The provision of care will be influenced by a number of factors including those discussed above, e.g. an ageing population, changing disease patterns, the issue of consumerism and technological advances. Often the provision of care is split between two areas:

- Acute care
- Chronic care.

Care also occurs within the following health-care settings:

- Primary
- Secondary
- Tertiary.

### *Primary care services*

Most care provision is carried out in the primary care sector, with over 95 per cent of care being delivered in this sector. Care is delivered outside hospitals by a range of practitioners, e.g.:

- Teams of nurses
- Groups of doctors
- Midwives
- Health visitors
- Dentists
- Pharmacists
- Optometrists
- Occupational therapists
- Physiotherapists
- Speech and language therapists.

For many patients, the professional health care that they need will be provided in the community setting. In some situations, the care provided by and in the primary care sector may not be appropriate or able to meet the needs of the patient, so referral to other services may be required – the services offered by the secondary care sector.

### *Secondary care services*

This aspect of care provision occurs mainly through the acute hospital setting. The nursing and medical staff who work in this area have more readily available access to specialist and elaborate diagnostic aids and facilities, e.g.:

- Radiology department
- Magnetic resonance imaging (MRI)

- Computed tomography (CT)
- Operating theatres
- Special care baby units (SCBUs)
- Microbiological laboratories.

Those who provide care in the primary care setting, e.g. the community nurse and GP, could be seen as the 'gatekeepers' to care provision in the secondary care sector, because they may make the necessary referrals. The transition from primary care to secondary care should be a seamless move. The distinction between the two is becoming more blurred because the patient may visit the hospital for just a few hours before having follow-up care in the community.

### *Tertiary care services*

In some larger hospitals there may be an opportunity to provide the patient with tertiary care, which is provided by nurses, doctors and other health-care professionals with specialist expertise, equipment and facilities for caring for the patient with complex health-care needs, e.g.:

- Intensive care units
- Burns units
- Oncology centres.

Often staff working in these areas will have undertaken additional courses to enable them to further develop their skills and knowledge. It is important to remember that most patients receive their care and have their needs met in the primary care setting. Only a few will need the services of those who work in the secondary care sector, and even fewer will need to access services provided in tertiary care.

Nurses can be found in all of these care settings. The biggest group of health-care professionals employed by the NHS are the 398 000 qualified nurses. *Modernising Nursing Careers* (DH, 2006b) sets out the establishment of a nursing career framework. The following descriptions of some nursing posts are provided only as a very brief explanation of the potential nursing career that may become available to you.

### *Chief Nursing Officer*

The Chief Nursing Officer (CNO) is the Government's most senior nursing adviser and has the responsibility to ensure that the Government's strategy for nursing is delivered. The CNO leads over 597 625 nurses, midwives and health visitors and other allied health professionals.

### *Nurse consultant*

Nurse consultants are very experienced practitioners. There is now a new range of these posts within all areas of nursing practice, in both the hospital and the community setting. One of the key aims of the post is to strengthen professional leadership, with four main areas of responsibility:

1. Expert practice
2. Professional leadership and consultancy

3. Education and development
4. Practice and service development linked to research and evaluation.

Most nurse consultants will spend approximately 50 per cent of their time in clinical practice, in direct contact with patients; their remaining time may be spent undertaking research, teaching, leadership and evaluation activities.

### *Clinical nurse specialist*

This nurse has acquired extensive specialist knowledge about a specific sphere of nursing. The clinical nurse specialist (CNS) works very closely with doctors who specialise in the same area of health care. There are many CNSs who run their own clinics and take on a caseload of patients, having full responsibility for making decisions about their care. CNSs work across the four fields of nursing in primary, secondary and tertiary care, and the independent and voluntary sectors. The following are some examples of CNSs:

- Skin cancer CNS
- Lymphoma CNS
- Head and neck CNS
- HIV CNS
- Rheumatology CNS
- Community adolescent mental health CNS

### *Advanced nurse practitioner*

An advanced nurse practitioner is defined by the RCN (2010) as a registered nurse who has undertaken a specific course of study of at least first degree (honours) level and who:

- makes professionally autonomous decisions, for which he or she is accountable
- receives patients with undifferentiated and undiagnosed problems, and assesses their health-care needs, based on highly developed nursing knowledge and skills, including skills not usually exercised by nurses, such as physical examination
- screens patients for disease risk factors and early signs of illness
- makes differential diagnosis using decision-making and problem-solving skills
- develops with the patient an ongoing nursing care plan for health, with an emphasis on preventive measures
- orders necessary investigations, and provides treatment and care individually, as part of a team and through referral to other agencies
- has a supportive role in helping people to manage and live with illness
- provides counselling and health education
- has the authority to admit or discharge patients from their caseload, and refer patients to other health-care providers as appropriate
- works collaboratively with other health-care professionals and disciplines
- provides a leadership and consultancy function as required.

## Modern matron

This role can be held by a male or female and can sometimes be called the clinical nurse manager. The role was reintroduced to offer support to ward sisters/charge nurses to enhance and focus attention on the patient experience. Veitch and Christie (2007) suggest that the modern matron has three key functions:

1. To provide leadership to staff who provide direct care in order to secure and assure the highest standards of clinical care within their group of wards or within the primary care setting
2. To ensure the availability of appropriate administrative and support services within their group of wards
3. To provide a visible, accessible and authoritative presence in ward settings.

## Ward sister/charge nurse

Ward sisters and their male counterparts, charge nurses, are experienced practitioners who have developed extensive skills and knowledge in their chosen area, e.g.:

- SCBU
- Adolescent mental health unit
- Oncology
- Nursing within a general hospital, e.g. acute mental health admissions wards
- Community practice, e.g. community team for learning disability
- Intensive care unit

The ward sister/charge nurse has many responsibilities, including leadership, acting as a role model and facilitating the learning of staff (such as registered nurses, student nurses and health-care assistants).

## Staff nurse

The staff nurse has completed a minimum of 3 years' education, usually at a higher education institution, and may be required, as he or she gains more experience, to act as deputy for the ward sister/charge nurse. Usually the staff nurse has his or her own group of patients to care for within the hospital or community setting. More experienced staff nurses can become facilitators/mentors to other junior members of the team.

# The code of professional conduct

Codes of professional conduct, also known as codes of ethics, are regularly updated and renewed (Castledine and Close, 2009); an ethical code for nurses in the UK dates back to 1983. Groups recognised as professionals adopt codes of conduct that guide the members of that professional group with regard to their professional behaviour. Nurses are guided with regard to standards for conduct, performance and ethics by way of *The Code: Standards of conduct, performance and ethics for nurses and midwives* (NMC, 2008). The code has been reproduced as Appendix 1.1 at the end of this chapter.

Professional codes for nurses aim to ensure that nurses work within ethical and moral frameworks. Codes of conduct are the collective and prevailing views shared by the profession, so the NMC's code of conduct is the ethical standard that all nurses should be working towards (Fryer, 2004; Clark, 2008; NMC, 2010a). The International Council for Nurses (ICN) has produced its own code. *The ICN Code of Ethics for Nurses* was used to help devise the first *Code of Professional Practice* in 1983 (UKCC, 1983) and is based on ethical principles (ICN, 2000).

## Think



Take some time to devise what you think should be contained within a code of professional conduct for nurses. What do you think are the most important standards that nurses ought to aim to adhere to?

You can check your code of conduct against the NMC's code of conduct in Appendix 1.1.

The code of conduct is not law; there is no legal imperative. It is a guide and, according to Koziar et al (2008), it informs the general public and other professionals of the standard of conduct that they should expect from registered nurses. Codes of conduct do not solve problems, but reflect professional morality. They operate in such a way as to remind the practitioner of the standards required by the profession. However, breaching the code of conduct is in effect a breach of registration and may lead to removal of the nurse's name from the register, and consequently of the right to practise.

The purpose of the code of professional conduct is to:

- inform the profession of the standard of professional conduct required of them in the exercise of their professional accountability and practice
- inform the public, other professions and employers of the standard of professional conduct that they can expect of a registered practitioner.

There are a number of key facets incorporated within the NMC's code of conduct and they are arranged, broadly, under the following headings.

### *Make the care of people your first concern, treating them as individuals and respecting their dignity*

- Treat people as individuals
- Respect people's confidentiality
- Collaborate with those in your care
- Ensure that you gain consent
- Maintain clear professional boundaries.

### *Work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community*

- Share information with your colleagues
- Work effectively as part of a team

- Delegate effectively
- Manage risk.

### *Provide a high standard of practice and care at all times*

- Use the best available evidence
- Keep your skills and knowledge up to date
- Keep clear and accurate records.

### *Be open and honest, act with integrity and uphold the reputation of your profession*

- Act with integrity
- Deal with problems
- Be impartial
- Uphold the reputation of your profession.

The principles enshrined within the code of conduct provide the professional framework from which practice is judged. Practice is judged with regard to professional standards – ethical and behavioural standards – ensuring that public protection occurs and the nurse is called to account for his or her actions or omissions. The code of conduct provides the nurse and the public with a clear message outlining personal accountability and a sense of moral responsibility.

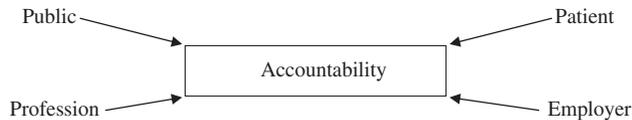
## Professional accountability

Whaite (2008) notes that health-care professionals have the potential to do much good as well as much harm to the people for whom they provide care, so the nurse should aim to maximise health and wellbeing. To be accountable the nurse must have up-to-date knowledge and the appropriate nursing skills. For this reason student nurses cannot be expected to be accountable because they may not have acquired the appropriate knowledge and skills.

Professional accountability is unremitting, and means that a nurse is accountable at all times for his or her actions or omissions, when on or off duty. The first section of the code of conduct makes it clear that, as a registered nurse or midwife, you are personally accountable for your practice, which means that you are answerable for your actions and omissions, regardless of advice or directions from another professional.

Carvalho et al (2011) suggest that sometimes the terms ‘accountability’ and ‘responsibility’ become confused. There are a number of important links between the two, but they are not the same and should not be used synonymously.

There are four arenas associated with accountability (Dimond, 2011) with which nurses may be faced (Figure 1.1).



**Figure 1.1** The four areas associated with accountability. (Source: adapted from Dimond, 2011.)

## Public accountability

Public accountability occurs through the criminal courts as defined by criminal law. In an instance where accountability is in question the police are likely to investigate and a decision may be made to prosecute the nurse for a criminal offence. Public accountability is generally associated with a social contract between the public and the profession.

## Accountability to the patient

The injured party may seek a civil remedy via criminal law in the criminal courts: the nurse may be sued for her or his actions or omissions – negligence. The person making the complaint or bringing the action for negligence can also, in certain circumstances, sue the NHS for the nurse's negligence (indirect liability). A sum of money in compensation may be paid to the injured party.

## Employer accountability

The employer expects the nurse to be accountable through the contract of employment. It is anticipated that every employee will obey the reasonable instructions of the employer and use due care and skill when carrying out his or her duties (Dimond, 2011). In some cases the employee may be in breach of contract if she or he has not acted with due care and skill, and disciplinary action may ensue.

## Accountability to the profession

The nurse is professionally accountable to the NMC through its Conduct and Competence Committee. The NMC, through this Committee, will determine if a nurse is deemed incompetent through his or her actions or omissions.

## Autonomy

Autonomy can be defined as self-determination, self-rule and being able to make decisions for one's self. It is a complex concept and can be used in a number of different ways (Aveyard, 2000). Dworkin (1988) notes a moral element to the term and suggests that it is about choosing a moral position and accepting responsibility for the kind of person that you are. Hendrick (2010) equates autonomy with:

- integrity
- dignity
- independence

- self-assertion
- critical reflection.

There are two perspectives associated with autonomy: a descriptive aspect and a prescriptive aspect. MacDonald (2002) suggests that descriptive autonomy is the capacity for self-governance and prescriptive autonomy is respect for autonomy, e.g. not interfering with a person's control over his or her own life.

## Top tips



The code states clearly that nurses must respect a person's autonomy: '... act as an advocate for those in your care, helping them to access relevant health and social care information and support.' When nurses respect a person's autonomy they must be aware of any legal implications. A person's right to accept or refuse treatment and care may change in law, depending on his or her age and health. Specific attention to the legal position of children must be sought, because their right to give consent or refuse treatment and care varies in the four countries of the UK, depending on their age.

Professional self-regulation – the ability of a profession to self-regulate or 'control' itself – will become a reality only if the members of that profession have autonomy to practise. Self-regulation can be seen as an unwritten contract between society and the nurse. Accountability is the primary consequence of professional nurse autonomy. Becoming an autonomous and independent professional is dependent on what the nurse knows and what he or she realises he or she does not know. Nurses need to be aware of their limitations as well as their clinical competence. It is important that nurses understand that, if there are any areas in which they are not clinically competent or they feel that it is unethical to undertake, then it is their duty to decline to undertake them. This is true autonomy – being aware of one's limitations.

There are many new opportunities for nurses to develop advanced roles and skills to improve the quality of patient care. Finn (2001) has demonstrated that there is a direct correlation between job satisfaction among registered nurses and their degree of autonomy. It remains, however, the overriding responsibility of nurses to ensure that they are adequately prepared for any new role and ensure patient safety as the role expands.

## Think



Thinking of the role of the nurse (in as many situations as you can), list the skills and the issues that he or she needs to possess in order to perform his or her duties with due care and attention with the ultimate aim of protecting the patient. By being aware of these issues the nurse is better placed to act as an autonomous practitioner.

You must by now have a very long list. Just one nursing action, e.g. feeding a patient, would require the nurse to consider many issues in order to act in the patient's best interests (Table 1.5). These are some of the skills that underpin safe nursing practice with respect to this one activity of living.

**Table 1.5** Some of the issues the nurse would need to take into account in order to perform safety and to act in the patient's best interests when feeding a patient

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- The patient's likes and dislikes
- Have the patient's nutritional needs been assessed?
- Does the nurse need to consult other health-care professionals such as:
  - nutritional nurse specialists
  - doctors
  - occupational therapists
  - speech and language therapists
  - dieticians?
- The patient's cultural beliefs (e.g. does he or she require a Halal-prepared meal)
- The patient's psychological/emotional status, e.g. does the patient have an appetite disturbance: anorexia nervosa, bulimia nervosa, obesity
- The patient's ability to swallow – his or her physiological status
- The patient's calorific needs – these vary with age
- Does the patient require any aids to eating?
- The nutritional value of the meal being served – your understanding of a balanced diet
- What is the patient's understanding of a balanced diet?
- Does the patient have the financial means to pay for a balanced diet? The patient may be living on a minimum income, if at all
- The level of independence/dependence
- The age of the patient, e.g. is the patient a neonate or an adolescent.
- Where the patient is being fed – eating is a part of social interaction, there may be customary influences
- Is the patient being fed orally or by tube?
- Is a prescription needed for the nutrients that the patient requires?

## Confidentiality

There are number of ethical concerns that come into play when the nurse attempts to deal with confidentiality. Ethical debates abound and often there are no right or wrong answers to the questions surrounding this very complicated principle. Confidentiality is closely related to the ethical principles of beneficence (to do good) and non-maleficence (to do no harm). This confirms the often used saying that 'confidentiality is the cornerstone of nursing'. The duty of confidentiality, according to Dimond (2010), arises from a variety of sources, including:

- A duty of care to the patient
- The contract of employment
- The code of conduct
- A number of laws.

Protecting confidentiality can be seen as respect for privacy (Miller and Webb, 2011). The right to a private life is upheld in the Human Rights Act 1998. Patients have a legitimate expectation that the nurse will respect their right to privacy and that he or she will act in an appropriate way when addressing and dealing with privacy and confidentiality.

An element of trust is needed by both the patient and the nurse for confidentiality to exist. In some instances that element of trust may not be agreed by the patient, because he or she may not be com-

petent to enter into a bilateral trust agreement. When this is the case, the duty owed should never be diminished. Mason and Whitehead (2003) point out that there must be an element of trust between both parties if there is to be an honest exchange of information and maintenance of secrecy. Without trust the therapeutic relationship between nurse and patient would be put in jeopardy: the patient may not be open and honest with the nurse. Patients place much trust in nurses and other health-care workers, e.g. doctors, so much so that patients allow nurses to perform intimate procedures on them and ask them personal questions in order to describe and reveal symptoms and problems that they may be experiencing (Hope et al, 2008).

There have been many changes in the ways in which health care has been delivered over the years; this has resulted in devising new ways of protecting patient information. The Department of Health ordered NHS organisations to appoint a Caldicott Guardian who was to be charged with specific responsibility for ensuring that confidential information was protected within their organisation (DH, 1997). The Caldicott Report (DH, 1997) led to the production of an NHS code of practice concerned with the issue of confidentiality (DH, 2003).

The NMC code of conduct (NMC, 2008), in relation to confidentiality, states clearly:

- You must respect people's right to confidentiality
- You must ensure that people are informed about how and why information is shared by those who will be providing their care
- You must disclose information if you believe that someone may be at risk of harm, in line with the law of the country in which you are practising.

Although it is commendable for any nurse to seek to ensure that the important ethical principle of confidentiality is maintained, this is often a complex issue and there may be many situations where this will be challenged (Dimond, 2010). Confidentiality is not an absolute principle, i.e. there are certain occasions when exemptions can be applied, and the confidence can be broken and the nurse override individual considerations, particularly when there may be implications for others – these instances are known as qualifications (Mason and Whitehead, 2003). Respect for a person's autonomy is an important component of confidentiality; however, when the confidence is broken the nurse could be said to be acting in a paternalistic manner: 'nurse knows best.' When maintaining a confidence, nurses are using the deontological ethical theory by keeping the patient's secret; conversely, they are acting in a utilitarian manner if they breach a confidence in order, for example, to safeguard the patient or others. In this instance nurses are operating in a maleficent manner (causing harm) as opposed to acting beneficently (the avoidance of doing harm).

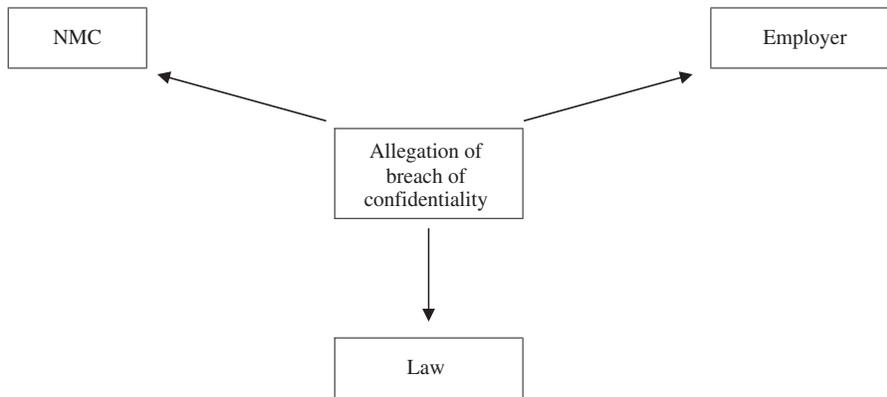
If confidentiality is violated an individual has the right to sue through the civil courts. The individual can also make a complaint to the Information Commissioner if there has been a breach of the Data Protection Act 1998 (RCN, 2005). The patient has a right to confidentiality in law:

- Common law
- Data Protection Act 1998
- Human Rights Act 1998.

The patient can also complain about the nurse's alleged breach of confidentiality to the NMC and/or the employer (Figure 1.2).

## What is confidential?

This question is not an easy one to answer. Information is provided to nurses in a variety of ways, in a range of situations from many people. Confidentiality is present when one person (the patient) discloses



**Figure 1.2** Ways in which the patient may pursue a claim alleging a breach of confidentiality.

information to another (the nurse), and the nurse given this information by the patient pledges not to disclose it to a third party without the patient's permission (NMC, 2009; Dimond, 2010). The nurse has already agreed or pledged not to disclose the information by virtue of being on the professional register and adhering to the tenets of the code of conduct.

## Think



A nurse goes home after a busy day working on an oncology ward and tells her partner about the events of day. She happens to tell her partner that a patient whom she has been nursing that day has developed a urinary tract infection.

Clearly a breach of confidentiality has occurred: the nurse has disclosed confidential information to a third party without the patient's permission. How serious do you think this breach of confidentiality is?

Now consider this: a nurse goes home after a busy day working on an oncology ward and tells her partner about the events of the day. She happens to tell her partner that a patient whom she has been nursing that day has tested positive for HIV.

Again a breach of confidentiality has occurred. How serious do you think this breach of confidentiality is?

You may have felt that on both counts the confidence breached was serious. You may have thought that telling her partner about a patient developing a urinary tract infection was not as serious as telling her partner about a patient with HIV. Why? Was it because the implications of having HIV may be considered more serious than a urinary tract infection or that there is potential for stigma to arise because of being HIV positive? In both cases a confidence was violated.

Often nurses understand and are aware of the need to maintain confidentiality. Dimond (2010) suggests that challenges occur when issues concerning disclosure arise: what are the exceptions to maintaining confidentiality and the circumstances that would allow the duty to be violated? The NMC (2009) stipulates that improper disclosure should be avoided at all times. Permission needs to be granted by the patient for the nurse to disclose the information to a third party. In practical terms it is not always

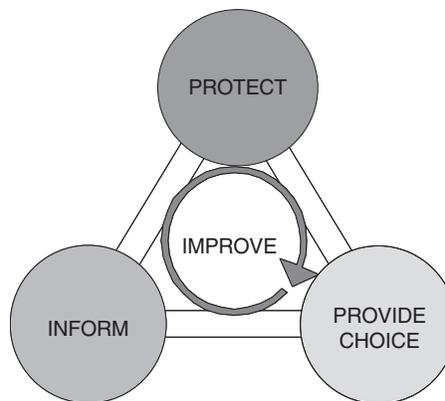
possible to seek permission to disclose information, but you must make the patient aware that there may be instances when the information obtained may be shared. There are many ways in which this can happen, e.g. by making explicit statements outlining the organisation's policy on the management of confidential information.

## The confidentiality model

The Department of Health has produced a model to help health-care professionals provide patients with a confidential service (DH, 2003). The model informs staff that they must inform patients of the intended use of the information that they provide, offer patients the choice to consent to or withhold their consent, as well as protecting the information that has been given (Figure 1.3).

### *Disclosure of confidential information*

There are a number of exceptions to the duty of confidentiality (Dimond, 2010). These are detailed in Table 1.6.



**Figure 1.3** The model of confidentiality. (Source: Department of Health, 2003.)

**Table 1.6** Seven exceptions that may allow the disclosure of confidential information

- With the patient's consent
- In the patient's interests
- Court order
- Statutory duty to disclose
- In the public's interests
- Police
- Provisions within the Data Protection Act 1998

Source: adapted from Dimond (2010).

## The patient's consent

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The duty to maintain consent or to provide a confidence is owed to the patient, and as such the patient has the authority to allow disclosures to be made. When the patient provides the nurse with permission to disclose, then there is no obligation to secrecy owed by the person receiving that consent (Mason and McCall-Smith, 2005). The nurse should check with the patient to whom information may be disclosed, e.g. family members and employers.

### Think



Martha is the nurse in charge of a gynaecology ward. One of her patients, Jean, has been admitted for a termination of pregnancy. Martha receives a telephone enquiry about Jean from a person saying he is Jean's father and asking how she is after the operation. Martha tells the caller that 'All went well'. He says he will be in later to pick her up and was it the gynaecology ward he needed to come to. Martha responds: 'Yes, the gynaecology ward on the third floor.' When Jean is fully awake Martha tells her that her father has called asking about her and that he will be in later to pick her up. Jean becomes very upset and tells Martha that she has no father and that her partner has threatened her if she goes ahead with the termination of pregnancy. Jean had told her partner that she was away with her mother for a few days. Later it transpires that her partner had thought she would go ahead with the termination despite his objections and he had contacted several clinics and hospitals in the city.

Was confidentiality breached, as Martha only said that 'All went well', she did not say what the operation was for?

Confidentiality has been breached – unauthorised information has been given without Jean's consent. The nurse confirmed (unwittingly) what the partner had thought, that Jean was on the gynaecology ward. Acknowledgement that the patient is on a particular ward or unit, e.g. a psychiatric unit or a breast screening unit, could be deemed disclosure.

Martha should have checked with Jean to whom she could disclose information, if it became necessary. The ward or unit should have a policy in place to help Martha with regard to disclosure of any information.

## Disclosure in the patient's interests

If information becomes known that would do the patient harm, then disclosure between the professionals involved in the patient's care would be justified. Dimond (2010) uses the problem of allergy to explain when disclosure in the patient's best interests may be permissible, e.g. if the patient has told a doctor he or she has an allergy to a specific medication, then the nurse and pharmacist would need to be informed of this in order to prevent the administration of a drug that could potentially harm the patient.

### Think



Jack is to undergo a right hip replacement. Jack has confided in you that he has a secret: he has hepatitis C and has not told the anaesthetist or the surgeon who have recently been to see him to talk about his operation tomorrow.

Having been given this information by Jack, whom, if anyone, might you tell – who needs to know? Your answer to this question may be ‘all those who care for him’, or nobody as it has been told to you in confidence. The list of people you may tell could include:

- the surgeon
- the anaesthetist
- the theatre nurses and theatre staff
- the ward nurses.

Would the following people also need to be informed?

- The staff who work in the pathology laboratory who may deal with Jack’s body fluids
- The porter who transports his body fluids to the laboratory for analysis
- The domestic who cleans his room
- The phlebotomist who takes his blood for analysis.

Those whom you do decide to tell (and you must only disclose in the patient’s best interests) would also be bound by the duty of confidentiality. Disclosure of confidential information to others is justified if it is necessary to protect the health of the patient or the professionals who are to care for him or her. You must decide whom they are and who truly needs to know, as opposed to those who may just be curious.

The response to this dilemma is difficult, because each case has to be considered on an individual basis. Each practitioner must decide on disclosure with regard to the specific circumstances (the context) associated with the individual case. Jack should have been told that information may be discussed and disclosed to other health-care professionals who care for him. The nurse should make every reasonable effort to persuade the patient to allow the information given to be disclosed to those who may need to know (Mason and McCall-Smith, 2005).

### *Disclosure by court order*

A court can demand a nurse to disclose information; this is known as a subpoena, and failure to disclose may render the nurse liable for contempt of court. There are, however, two grounds where the power of the court may fail to ensure disclosure and they are known as being privileged from disclosure. Public interest immunity is associated with national security and disclosure would be contrary to the public interest. Legal professional privilege is the second exception: this exception is associated with communications where litigation may occur or is taking place.

### *Statutory duty*

There are statutory duties that will result in disclosure (regardless of the patient’s wishes). Confidential information must be made known by law under the Acts detailed in Table 1.7. The NMC (2011b) note that ‘public interest’ describes the exceptional circumstances that justify overruling the right of an individual to confidentiality in order to serve a broader social concern.

Staff are permitted under common law to disclose personal information but this must be done in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to other people. It is essential that each case be judged on its merits. The NMC (2011b) provide examples where disclosing information in relation to crimes against the person may be

**Table 1.7** Statutory requirements to disclose

Act	Requirement
Road Traffic Act 1988	Any person is required to provide the police with information that is related to a road traffic accident that results in personal injury
Prevention of Terrorism Act 2005	Any person who has information that he/she feels may be of assistance in the prevention of terrorism or apprehension of terrorists must make this known to the police
Public Health (Control of Diseases) Act 1984	Any notifiable disease (e.g. plague, typhus, food poisoning), the name and the whereabouts of the person with the notifiable disease must be reported to the medical officer of the district
Abortion Act 1967	Doctors must report to the Chief Medical Officer any information relating to termination of pregnancy
Births and Deaths Registration Act 1953	Authorities must be notified of births and deaths

acceptable, e.g. rape, child abuse, murder, kidnapping, or as a result of injuries sustained from knife or gun-shot wounds.

These are complex decisions and must take account of the public interest in ensuring confidentiality against the public interest in disclosure. Disclosures should be proportionate and limited to relevant details.

### *Public interest*

Disclosure is allowed if this is in the public interest. The major concern with disclosure under the heading of public interest is that there is no definition of public interest in law. Disclosure is referred to in the code of conduct (NMC, 2008); the nurse must disclose information if there is a belief that someone may be at risk of harm, but disclosure must be in line with the law. Disclosure of information must occur only if there is a need to protect the patient or someone else from significant harm and is for the good of society. Often disclosure would be justified if a serious crime had been committed, e.g. murder, child abuse or drug trafficking. Public interest has already been alluded to in the statutory duty to disclose. The DH (2010c) have produced supplementary guidance with regard to public interest disclosure.

### *Disclosure to the police*

During a police investigation there may be instances where the police ask a nurse to disclose information. There is no general legal duty to provide the police with information (apart from the issues described above). It is, however, an offence to obstruct police investigations by providing false or misleading information. No offence will have been committed if the nurse refuses to answer questions posed by police, provided that the nurse has a lawful excuse for refusing, i.e. duty of confidentiality (Hendrick, 2004). A circuit judge can order that medical records be released to the police and the coroner can ask to see the medical records of a dead patient (Hope et al, 2008).

## *The Data Protection Act 1998 and disclosure of information*

Under the Data Protection Act 1998 every living person has the right to apply for access to their health records, including electronic and manual records (Hope et al, 2008). There are nine key principles associated with the Act, which aim to ensure that the data held are:

- accurate
- relevant
- held only for specific defined purposes for which the user has been registered
- not kept for longer than is necessary
- not disclosed to any unauthorised person.

The Act allows data subjects (patients) to be:

- informed as to whether personal data is processed
- provided with a description of the data held, the purposes for which it is processed and knowledge of the people to whom the data may be disclosed
- provided with a copy of the information constituting the data
- given information on the source of the information.

There is also provision within the Act to allow a person to have the information rectified and inaccuracies corrected. As a result of these inaccuracies, the patient may also have the right to receive compensation for the erroneous entries that had been made.

A request, in writing, must be made by the patient to gain access to his or her records and a response to this request is then given to the patient within 40 days of the request being made. Although provisions are made to enable the patient to gain access to medical records, certain information may be withheld in some circumstances. If it is deemed that the information could cause harm to the patient, access can be denied. The following are some of the circumstances:

- Potential physical or mental harm
- If the request is made by some person other than the patient, e.g. a parent
- If access would reveal the identity of another person, unless that other person has given their consent (this does not apply if the other person is a health-care professional who has been involved in the care of the patient, unless serious harm to that health-care professional's physical or mental health is likely to be caused by allowing access).

## Case study 1.2



Ms Sarah Orford is a young woman aged 18 years of age with learning disabilities. You are working with Ms Orford and she divulges to you confidentially that she is having some difficulties with her boyfriend, Mark (Mark also has learning disabilities; he is 20 years of age). Sarah and Mark both want to have sex but they are not sure about safe sex and what this means. Sarah and Mark's parents know nothing of their intentions.

What will do you in helping Ms Orford and her partner? You have a duty of care to Ms Orford. You might advise the couple of the various organisations that provide up-to-date information in user-friendly format which might provide them with some knowledge of safe sex, what it is and how to carry it out.

You can also let them know that these organisations often offer support and help in talking over issues associated with safe sex.

## Professional misconduct

A breach of the Code may constitute professional misconduct or unprofessional conduct. Anyone can make a complaint about a nurse to the NMC. Complaints come to the NMC via various routes, e.g. the general public, fellow nurses, colleagues in other health-care professions and employers. Most complaints about nurses are usually resolved locally and this is the preferred way of dealing with complaints in the first instance.

Professional misconduct can occur when the nurse has not abided by the rules set by the NMC, often in the form of the code of conduct, bearing in mind that nurses are also subjected to any of the elements of the general law that affect every citizen. The NMC has a legal duty to protect the public and in so doing has the power to exercise disciplinary procedures.

Bringing about disciplinary procedures cannot, and must not, be driven by professional self-interest – the patient first and foremost is the maxim. The key aim is to determine if that unwritten contract referred to earlier has been honoured, by ensuring that any nurse who is deemed to have failed to meet the trust that society places in him or her is not permitted to continue to practise if the allegation is proven.

The NMC will take action whenever a nurse's fitness to practise is impaired because of misconduct, illness, incompetence, criminal conviction or cautions. Professional misconduct can be said to have occurred if a nurse's behaviour has fallen short of what can reasonably be expected of a nurse. If a nurse fails to follow the code, that nurse may be guilty of misconduct and as a consequence may not be fit to practise.

Fitness to practise is the nurse's suitability to be on the register; without restrictions this may mean:

- Failing always to put the patient's interests first
- Not being properly trained, qualified and up to date
- Failing to treat patients with respect and dignity
- Not speaking up for patients who cannot speak for themselves.

## Think



Make a list of what you think might be the most common examples of professional misconduct.

You may have some of the items below on your list. It is not possible to provide a definitive list of complaints that the NMC investigates. However, the NMC (2010c) considers these to be the most common examples of allegations of unfitness to practise (this is not an exhaustive list):

- Physical, sexual or verbal abuse
- Significant failure to provide adequate care

- Significant failure to keep proper records
- Failure to administer medicines safely
- Deliberately concealing unsafe practice
- Committing criminal offences
- Continued lack of competence despite opportunities to improve
- Theft
- Health conditions.

## Case study 1.3



Ms Camille Olabieje, a registered adult nurse, was found to be treating residents in a hostile and inappropriate manner while working at a care home in Edinburgh. Charges including knowingly feeding two residents with dementia contrary to their requirements, pushing a resident forcefully, shouting aggressively at residents and colleagues, and grabbing residents' hands hard enough to cause the skin to redden were made against Ms Olabieje.

The Fitness to Practise panel ruled that Ms Olabieje's behaviour was unacceptable; she fell far short of the behaviour expected from someone in the nursing profession. In order to maintain the good reputation of the profession and public confidence in the NMC, the panel agreed to strike Ms Olabieje off the register.

## Lack of competence

A lack of competence relates to a lack of knowledge, skill or judgement of such a nature that the nurse is unfit to practise in a safe and effective manner (NMC, 2010c). Some examples of lack of competence can include:

- A persistent lack of ability in correctly and/or appropriately calculating and recording the administration or disposal of medicines
- A persistent lack of ability in properly identifying care needs and, accordingly, planning and delivering appropriate care
- Inability to work as part of a team
- Difficulty in communicating with colleagues or people in their care.

## Conviction or caution

The following may lead to a finding of unfitness to practise in relation to a conviction or caution:

- Theft
- Fraud or other dishonest activities
- Violence
- Sexual offences
- Accessing or downloading child pornography or other illegal material from the internet
- Illegally dealing or importing drugs.

## Health conditions

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There are certain health conditions that may lead the NMC to question a nurse's fitness to practise:

- Long-term, untreated alcohol or drug dependence
- Unmanaged serious mental illness.

## The NMC committees

When a complaint about a nurse is made and all the supporting evidence has been submitted to the NMC, the case is then referred onwards. Three committees handle and deal with all complaints of any allegation of unfitness to practise made against nurses; these are known as policy committees. Other committees make decisions about the governance of the NMC, e.g. the Audit, Risk and Assurance Committee and the Business Planning and Governance Committee.

In the first instance a triage team deal with any referral made to the NMC; this team checks to ensure that the person about whom the referral is being made is on the NMC register and that the nature of the complaint is something that the NMC should be involved with.

A case progression team then receives the referral if the triage team is content that there are grounds for a case. Information about the referral will be collected and then the case is progressed to the independent adjudication committees. The case referral team always send the nurse a copy of the allegations made against them along with supporting information; the nurse is then invited to make a written response. Depending on the case specific information will be required and will include:

- The name of the person making the referral, job title and contact details
- Details about the nurse being referred – name and PIN, the nurse's job at the time of the allegation(s) and key aspects of that post
- Details about the complaint and a clear summary
- Incidents relating to the complaint, when and where the incident took place, the type of place the nurse was employed in at the time, who was there, the context and circumstances of any incident(s)
- Details of any witnesses and copies of their statements
- Previous action – details of any other agency that may have been contacted, e.g. the police, notes and transcripts of any internal investigations
- Other supporting evidence, e.g. an internal investigating report, copies of service users' medical records, sickness record.

The case progression team then refers the case to the Investigating Committee along with all the supporting information.

## The Investigating Committee

The Investigating Committee deals with all allegations. This committee meets in private and is made up of nurses, midwives and laypeople outside the two professions. All the evidence is considered by this panel, including evidence from the nurse who has been referred. The panel may seek expert advice. The panel then makes a decision as to what kind of further investigation is required and whether or not there is a case to answer. In deciding if there is a case to answer, the Investigating Committee must be reasonably satisfied that the facts of the allegation can be proved and if proved those facts could lead to finding that a nurse's fitness to practise is impaired (NMC, 2010e). If this panel determines that there

is no case to answer then the case is closed. However, if it finds otherwise the case is then referred to either the Conduct and Competence Committee or the Health Committee. In 2008–2009, 2178 referrals were made to the NMC (this is just 0.3% of all of those on the register) and only 1759 required further investigation (NMC, 2010e).

## The Conduct and Competence Committee and the Health Committee

Depending on the type of case, referral is made by the Investigating Committee to either the Conduct and Competence Committee or the Health Committee who then convene a hearing and final adjudication. Just as the Investigation Committee is totally independent from the NMC so are these two committees and the panels are made up of registered nurses, midwives and laypeople (people from outside the two professions). There are a number of allegations that these two committees are requested to adjudicate on, including:

- Dishonesty
- Patient abuse
- Lack of competence
- Failure to maintain adequate records
- Incorrect administration of drugs
- Neglect of basic care
- Unsafe clinical practice
- Failure to collaborate with colleagues
- Colleague abuse
- Failure to report incidents
- Failure to act in an emergency
- Accessing pornography
- Violence.

The panel's convened aim is to determine if the nurse's fitness to practise has been impaired; if this is the case then appropriate action is taken. Conduct and competence cases are usually heard in public; it is unusual for a case that has been referred to the Health Committee to be heard in public.

The panel members of the relevant committee review the information that they have been given; they can take legal advice and question employers as well as the nurse or her or his representative. Witnesses may be called to give their account of the situation; however, this is not always the case. Witnesses are usually called if there is any dispute about the facts of the case. Vulnerable witnesses are protected and there are special provisions. The anonymity of patients and clients is also protected.

## Arriving at a decision

The panel may conclude that the nurse's fitness to practise has been impaired (they decide if the nurse is fit to stay on the register). Decisions made are not intended to be punitive; they are made to safeguard the health and wellbeing of the public. The standard of proof used is the civil standard of proof (the balance of probabilities). The decision-making process goes through three stages:

1. Are the facts proven or not?
2. Is the fitness of practise of the nurse impaired?
3. What actions will be needed to safeguard the health and wellbeing of the public?

Before the Committees consider the action that they will take, they have to take into account issues such as:

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- Previous disciplinary action taken and how the nurse responded to this
- The availability of training and support
- Staffing issues that may have had an impact on the nurse's performance
- Unreasonable role demands.

There are five options open to the panel if the nurse's fitness to practice has been impaired.

1. The panel can decide not to take any action or to make one of the following four orders
2. Striking off order: the nurse's name is removed from the register for 5 years and he or she is not allowed to work as a nurse in the UK
3. A suspension order: the nurse is suspended from duty for a set period of time
4. A conditions of practice order: this order restricts a nurse's practice for between 1 and 3 years, e.g. he or she may be restricted from working in a particular setting
5. A caution order: the nurse is cautioned for the behaviour but is not prevented from practising. This order can last for between 1 and 5 years.

Interim suspension or interim conditions of practice orders can be made in exceptional circumstances. These orders can be made before either the Conduct and Competence Committee or the Health Committee has heard the case. Such orders usually mean that the allegation is of a serious nature and there may be a risk to the public or to the nurse.

Restoration to the register can and does happen. Any nurse removed from the register has the right to apply to have his or her name restored. The Conduct and Competence Committee or the Health Committee considers cases of restoration. If restoration is to be granted the nurse must be able to demonstrate as a minimum that he or she:

- understands and accepts the reason for removal.
- has undertaken appropriate action to address the problems that led to removal.
- has been working in a related field of care for a significant period of time and has demonstrated exemplary standards of conduct during that time.
- has support for the application for restoration with impeccable references from the current employer and, if deemed appropriate, from a medical practitioner.

Meeting the above conditions, however, does not provide an automatic restoration to the register. In some circumstances appeals to an appropriate court are possible against any of the sanctions stated earlier.

## Conclusions

Becoming a competent registered nurse brings with it many privileges, one of which is the privilege of working with the public and providing them with a service that is safe and of a high quality. From a historical perspective nurses and nursing have travelled a long way, and nursing and nurses are now seen as professionals working comfortably and confidently alongside other health-care professionals.

The regulation of nurses has evolved since 1919 when the Nurses Registration Acts were passed. The regulatory framework enhances practice and serves to protect the public. Entry to the professional reg-

ister also means that the nurse has the right to practise as an autonomous practitioner, but this has to be with the patients' best interests at the core of professional practice. Professional self-regulation, i.e. the ability of the nursing profession to self-regulate or 'control' itself, becomes a reality when nurses embrace the ability to practise in an autonomous manner. Self-regulation can be seen as an unwritten contract between society and the nurse.

Registered nurses are personally accountable for their practice. This means that they are answerable for their actions and omissions, regardless of advice or directions from another professional or any other party. No one else can answer for the actions or omissions and it is no defence for the nurse to say that he or she was acting on someone else's orders.

Students of nursing are never professionally accountable in the same way as they are when they become registered practitioners. It is the registered practitioner with whom the student nurse works who is professionally responsible for the consequences of the student's actions or omissions. Student nurses must always work under the direct supervision of a registered nurse or midwife (NMC, 2010d). The NMC have produced guidance on professional conduct for nursing and midwifery students (NMC, 2010d). This guidance sets out the personal and professional conduct expected of nursing and midwifery students in order for them to be deemed fit to practise. It is based on the standards laid out in the professional code of conduct for registered nurses and midwives – the code that all registered nurses and midwives are required to follow when they register with the NMC. Students work towards these standards during their preregistration programmes of study.

A code of conduct is one hallmark of a profession. It must be remembered that the code of conduct is not law; there is no legal imperative – it is merely a guide. The code of conduct does not solve problems; it reflects professional morality and operates in such a way as to remind the nurse of the standards required by the profession. Furthermore, it guides nurses in the direction of their duties to patients. Breach of the tenets within the code of conduct is in effect a breach of registration and can lead to removal of the nurse from the register and the privileged right to practise.

Self-regulation serves to protect the public. To be seen to be effective those who fall short of upholding the good standing of the profession or bring the profession into disrepute may be found culpable of professional misconduct. Failure to put the patient's best interests first, failing to treat patients with respect and dignity, and not being up-to-date with practice are examples of incompetence that can lead to sanctions being applied. There is a range of sanctions that may be imposed on a nurse whose fitness to practise has been impaired.

When complaints are received about a nurse's fitness to practise the case is referred to the Investigating Committee, which then decides if a case is to be answered. If no case is to be answered the complaint is dismissed. However, if the Investigating Committee considers that the complaint must be investigated further, the case is referred to either the Conduct and Competence Committee or the Health Committee. Interim suspension or interim conditions of practice orders can be made in exceptional circumstances, but this is rare. Such orders usually mean that the allegation is of a serious nature and there may be a risk to the public or the individual nurse.

Restoration to the register can and does happen. Any nurse has the right to apply to have his or her name restored to the register. However, conditions must be met before restoration, as determined by either the Conduct and Competence Committee or the Health Committee. Appeals can be made to an appropriate court in respect to any sanctions applied.

## Activities

Attempt the following 10 questions that are related to the code of professional conduct to test your knowledge. The answers can be found at the back of this book, in the section called 'Activity Answers'.

1. What date was the current Code of Conduct published?
  - a. 1994
  - b. 2001
  - c. 2008
  - d. 2005
2. Who published the Code of Conduct?
  - a. The RCN
  - b. The NMC
  - c. The Department of Health
  - d. The Council of deans
3. The Code of Conduct is:
  - a. A legal document
  - b. A document produced to protect the nurse
  - c. An advisory document
  - d. A document used for disciplinary purposes for the student
4. Who does the document concern?
  - a. Children and families
  - b. Children's nurses
  - c. All nurses and midwives
  - d. All health-care professionals
5. Where can copies be obtained?
  - a. The university learning resource centre
  - b. The NMC website
  - c. The NMC
  - d. All of the above
6. Which of the following are documents that the NMC does not produce?
  - a. Administration of medicines
  - b. Records and record keeping
  - c. National Service Frameworks
  - d. Manual removal of faeces
7. The key aim of the NMC is to:
  - a. Protect and serve the public
  - b. Protect the best interests of the nurse
  - c. Provide an annual report to the ombudsman
  - d. Generate income
8. How many parts are there to the professional register?
  - a. 1
  - b. 14
  - c. 3
  - d. 16
9. Which of the following statements is true?
  - a. The NMC is a commercial enterprise.
  - b. All doctors must have live registration with NMC in order to practise.

- c. The NMC is an organisation set up by Parliament to ensure that nurses and midwives provide high standards of care to their patients and clients.
  - d. Membership to the NMC is open to all health-care professionals.
10. When was the NMC created?
- a. December 2002
  - b. April 2003
  - c. April 2002
  - d. December 2003

## References

- Anionwu EN (2005) *A Short History of Mary Seacole. A resource for nurses and students*. London: Royal College of Nursing.
- Aveyard H (2000) Is there a concept of autonomy that can usefully inform nursing practice? *Journal of Advanced Nursing* **32**: 352–358.
- Benner P (1984) *From Novice to Expert*. Menlo Park, CA: Addison Wesley.
- Burnard P, Chapman C (2003) *Professional and Ethical Issues in Nursing*, 3rd edn. London: Ballière Tindall.
- Cameron A, Masterson A (2003) Reconfiguring the clinical workforce. In: Davies C (ed.), *The Future Health Workforce*. Basingstoke: Palgrave, pp 68–83.
- Carvalho S, Reeves M, Orford J (2011) *Fundamental Aspects of Legal, Ethical and Professional Issues in Nursing*, 2nd edn. London: Quay Books.
- Castledine G, Close A (2009) *Oxford Handbook of Adult Nursing*. Oxford: Oxford University Press.
- Clark J (2008) What is nursing. In: Hinchliff S, Norman S, Schober J (eds), *Nursing Practice and Health Care. A foundation text*, 5th edn. London: Hodder Arnold, pp 18–41.
- Craig C (2010) Evolution of nursing practice. In: Daniels R (ed.), *Nursing Fundamentals: Caring and clinical decision making*, 2nd edn. New York: Delmar, pp 2–25.
- Davies C, Beach A (2000) *Interpreting Professional Regulation*. London: Routledge.
- Department of Health (1997) *The Caldicott Committee: Report on the Review of Patient Identifiable Information*. London: DH.
- Department of Health (2003) *Confidentiality: NHS Code of Practice*. London: DH.
- Department of Health (2006a) *Hospital at Night. Baseline Report*. London: DH.
- Department of Health (2006b) *Modernising Nursing Careers – Setting the Direction*. London: DH.
- Department of Health (2007) *Trust, Assurance and Safety: The regulation of healthcare professionals in the 21st century*. London: The Stationery Office. Available at: [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_065947.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_065947.pdf) (accessed May 2011).
- Department of Health (2010a) *Equity and Excellence: Liberating the NHS*. London: DH.
- Department of Health (2010b) *Healthy Lives, Healthy People: Our strategy for public health in England*. London: DH.
- Department of Health (2010c) *Supplementary Guidance: Public interest disclosures*. London: DH.
- Dimond B (2010) *Legal Aspects of Patient Confidentiality*, 2nd edn. London: Quay Books.
- Dimond B (2011) *Legal Aspects of Nursing*, 6th edn. Harlow: Pearson.
- Dworkin G (1988) *The Theory and Practice of Autonomy*. Cambridge: Cambridge University Press.
- Etzioni A (1969) *The Semi-Professions and Their Organization: Teachers, nurses and social workers*. New York: Free Press.
- Finn CP (2001) Autonomy: An important component for nurses' job satisfaction. *International Journal of Nursing Studies* **38**: 349–357.
- Fryer N (2004) Principles of professional practice. In: Hinchliff S, Norman S, Schober J (eds), *Nursing Practice and Health Care*, 4th edn. London: Arnold, pp 27–47.
- Hallet CE (2010) *Celebrating Nurses. A Visual History*. London: Fil Rouge Press.

- Henderson V (1966) *The Nature of Nursing: A definition and its implications for practice, research and education*. New York: Macmillan.
- Hendrick J (2004) *Law and Ethics*. Cheltenham: Nelson Thorne.
- Hendrick J (2010) *Law and Ethics in Children's Nursing*. Chichester: Wiley-Blackwell.
- Hood LJ (2010) *Conceptual Bases of Professional Nursing*, 7th edn. Philadelphia, PA: Lippincott.
- Hope T, Savulescu J, Hendrick J (2008) *Medical Ethics and Law: The core curriculum*, 2nd edn. Edinburgh: Churchill Livingstone.
- International Council of Nurses (2000) *The ICN Code of Ethics for Nurses*. Geneva: ICN.
- Kozier B, Erb G, Berman A, Snyder S, Lake R, Harvey S (2008) *Fundamentals of Nursing. Concepts, Process and Practice*. Harlow: Pearson.
- Longley M, Shaw C, Dolan G (2007) *Nursing: Towards 2015: Alternative Scenarios for Healthcare, Nursing and Nurse Education in the UK in 2015*. Pontypridd: University of Glamorgan.
- MacDonald C (2002) Nursing autonomy as relational. *Nursing Ethics* 9: 194–201.
- McGann S, Crowther A, Dougall R (2009) *A History of the Royal College of Nursing 1916–1990. A Voice for Nurses*. Manchester: Manchester University Press.
- Mason JK, McCall-Smith RA (2005) *Law and Medical Ethics*, 7th edn. Oxford: Oxford University Press.
- Mason T, Whitehead E (2003) *Thinking Nursing*. Milton Keynes: Open University Press.
- Miller E, Webb L (2011) Active listening and attending; communication skills and the healthcare environment. In: Webb L (ed.), *Nursing: Communication skills in practice*. Oxford: Oxford University Press, 52–71.
- NHS Information Centre (2011) *NHS Staff 1996–2006 Overview*. Available at: [www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1996-2006-overview](http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1996-2006-overview) (accessed May 2011).
- Nightingale F (1859a) *Notes on Hospitals*. London: John W. Parker & Sons.
- Nightingale F (1859b) *Notes on Nursing: What it is and what it is not*. Glasgow & London: Blackie & Son Ltd.
- Nursing and Midwifery Council (2004) *Standards of Proficiency for Specialist Community Public Health Nurses*. London: NMC.
- Nursing and Midwifery Council (2008) *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*. London: NMC.
- Nursing and Midwifery Council (2009) *Advice Sheet. Confidentiality (A to Z Guidance)*. London: NMC.
- Nursing and Midwifery Council (2010a) *Good Health and Good Character: Guidance for approved education institutions*. London: NMC.
- Nursing and Midwifery Council (2010b) *Standards for Preregistration Nursing Education*. London: NMC. Available at: <http://standards.nmc-uk.org/PublishedDocuments/Standards%20for%20pre-registration%20nursing%20education%2016082010.pdf> (accessed July 2011).
- Nursing and Midwifery Council (2010c) *The PREP Handbook*. London: NMC.
- Nursing and Midwifery Council (2010d) *Guidance on Professional Conduct for Nursing and Midwifery Students*. London: NMC.
- Nursing and Midwifery Council (2010e) *Advice and Information for Employers of Nurses and Midwives*. London: NMC.
- Nursing and Midwifery Council (2011a) *Statistical Analysis of the Register 1 April 2007 to 31 March 2008*. London: NMC. Available at: [www.nmc-uk.org/Documents/Statistical%20analysis%20of%20the%20register/NMC-Statistical-analysis-of-the-register-2007-2008.pdf](http://www.nmc-uk.org/Documents/Statistical%20analysis%20of%20the%20register/NMC-Statistical-analysis-of-the-register-2007-2008.pdf) (accessed May 2011).
- Nursing and Midwifery Council (2011b) *Confidentiality*. London: NMC. Available at: [www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Confidentiality](http://www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Confidentiality) (accessed December 2011).
- Pyne R (1998) *Professional Disciplines in Nursing, Midwifery and Health Visiting*, 3rd edn. Oxford: Blackwell Scientific Publications.
- Royal College of Nursing (2003) *Defining Nursing*. London: RCN.
- Royal College of Nursing (2005) *Confidentiality: RCN Guidance for Occupational Health Nurses*. London: RCN.
- Royal College of Nursing (2010) *Advanced Nurse Practitioners – an RCN Guide to the Advanced Nurse Practitioner Role, Competences and Programme Accreditation*. London: RCN.
- Salvage J (2002) *Rethinking Professionalism: The First Step for Patient Focused Care*. London: Institute for Public Policy Research.
- Salvage J (2003) Nursing today and tomorrow. In: Hinchliff S, Norman S, Schober J (eds), *Nursing Practice and Health Care*, 4th edn. London: Arnold, pp 1–24.

- United Kingdom Central Council (1983) *Code of Professional Practice*. London: UKCC.
- United Kingdom Central Council (1986) *Project 2000 – A New Preparation for Practice*. London: UKCC.
- United Kingdom Central Council (1999) *Fitness for Practice: The UKCC Commission for Nursing and Midwifery Education*. London: UKCC.
- Veitch L, Christie J (2007) Evolution of contemporary nursing. In: Brooker C, Waugh A (eds), *Nursing Practice. Fundamentals of Holistic Care*. Edinburgh: Mosby-Elsevier, pp 37–70.
- Whaite I (2008) Professional standards and rules: the professional regulatory body and the nursing student. In: Spouse J, Cook M, Cox C (eds) *Common Foundation Studies in Nursing*, 4th edn. Edinburgh: Churchill Livingstone, pp 89–124.
- Webb L (2011) Communication for personal and professional development. In: Webb L (ed.), *Nursing: Communication skills in practice*. Oxford: Oxford University Press, pp 300–312.
- Williamson GR, Jenkinson T, Proctor Childs T (2010) () *Contexts of Contemporary Nursing*, 2nd edn. Exeter: Learning Matters.

## Appendix 1.1

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### The code: Standards of conduct, performance and ethics for nurses and midwives

Source: reproduced with permission Nursing and Midwifery Council (2008) ([www.nmc-uk.org.uk](http://www.nmc-uk.org.uk))

The people in your care must be able to trust you with their health and wellbeing.

To justify that trust, you 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 wellbeing 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 professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions.

You must always act lawfully, whether those laws relate to your professional practice or personal life.

Failure to comply with this code may bring your fitness to practise into question and endanger your registration.

This code should be considered together with the Nursing and Midwifery Council's rules, standards, guidance and advice available from [www.nmc-uk.org](http://www.nmc-uk.org).

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

Treat people as individuals:

1. You must treat people as individuals and respect their dignity
2. You must not discriminate in any way against those in your care
3. You must treat people kindly and considerately
4. You must act as an advocate for those in your care, helping them to access relevant health and social care, information and support

Respect people's confidentiality:

5. You must respect people's right to confidentiality
6. You must ensure that people are informed about how and why information is shared by those who will be providing their care
7. You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising

Collaborate with those in your care:

8. You must listen to the people in your care and respond to their concerns and preferences
9. You must support people in caring for themselves to improve and maintain their health
10. You must recognise and respect the contribution that people make to their own care and wellbeing
11. You must make arrangements to meet people's language and communication needs
12. You must share with people, in a way that they can understand, the information that they want or need to know about their health

Ensure that you gain consent:

13. You must ensure that you gain consent before you begin any treatment or care
14. You must respect and support people's rights to accept or decline treatment and care
15. You must uphold people's rights to be fully involved in decisions about their care
16. You must be aware of the legislation regarding mental capacity, ensuring that people who lack capacity remain at the centre of decision-making and are fully safeguarded
17. You must be able to demonstrate that you have acted in someone's best interests if you have provided care in an emergency

Maintain clear professional boundaries:

18. You must refuse any gifts, favours or hospitality that might be interpreted as an attempt to gain preferential treatment
19. You must not ask for or accept loans from anyone in your care or anyone close to them
20. You must establish and actively maintain clear sexual boundaries at all times with people in your care, their families and carers

Work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community.

Share information with your colleagues:

21. You must keep your colleagues informed when you are sharing the care of others
22. You must work with colleagues to monitor the quality of your work and maintain the safety of those in your care
23. You must facilitate students and others to develop their competence

Work effectively as part of a team:

24. You must work cooperatively within teams and respect the skills, expertise and contributions of your colleagues
25. You must be willing to share your skills and experience for the benefit of your colleagues
26. You must consult and take advice from colleagues when appropriate
27. You must treat your colleagues fairly and without discrimination
28. You must make a referral to another practitioner when it is in the best interests of someone in your care

Delegate effectively:

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

Manage risk:

32. You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk
33. You must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards
34. You must report your concerns in writing if problems in the environment of care are putting people at risk

Provide a high standard of practice and care at all times.

Use the best available evidence:

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- 35.** You must deliver care based on the best available evidence or best practice
- 36.** You must ensure that any advice you give is evidence based if you are suggesting healthcare products or services
- 37.** You must ensure that the use of complementary or alternative therapies is safe and in the best interests of those in your care

Complementary alternative therapies and homeopathy.

Keep your skills and knowledge up to date:

- 38.** You must have the knowledge and skills for safe and effective practice when working without direct supervision
- 39.** You must recognise and work within the limits of your competence
- 40.** You must keep your knowledge and skills up to date throughout your working life
- 41.** You must take part in appropriate learning and practice activities that maintain and develop your competence and performance

Keep clear and accurate records.

Record keeping: guidance for nurses and midwives:

- 42.** You must keep clear and accurate records of the discussions that you have, the assessments that you make, the treatment and medicines that you give and how effective these have been
- 43.** You must complete records as soon as possible after an event has occurred
- 44.** You must not tamper with original records in any way
- 45.** You must ensure that any entries you make in someone's paper records are clearly and legibly signed, dated and timed
- 46.** You must ensure any entries you make in someone's electronic records are clearly attributable to you
- 47.** You must ensure all records are kept securely

Be open and honest, act with integrity and uphold the reputation of your profession.

Act with integrity:

- 48.** You must demonstrate a personal and professional commitment to equality and diversity
- 49.** You must adhere to the laws of the country in which you are practising
- 50.** You must inform the NMC if you have been cautioned, charged or found guilty of a criminal offence
- 51.** You must inform any employers you work for if your fitness to practise is called into question

Deal with problems:

- 52.** You must give a constructive and honest response to anyone who complains about the care they have received
- 53.** You must not allow someone's complaint to prejudice the care that you provide for them
- 54.** You must act immediately to put matters right if someone in your care has suffered harm for any reason
- 55.** You must explain fully and promptly to the person affected what has happened and the likely effects
- 56.** You must cooperate with internal and external investigations

Be impartial:

57. You must not abuse your privileged position for your own ends
58. You must ensure that your professional judgement is not influenced by any commercial considerations

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Uphold the reputation of your profession:

59. You must not use your professional status to promote causes that are not related to health
60. You must cooperate with the media only when you can confidently protect the confidential information and dignity of those in your care
61. You must uphold the reputation of your profession at all times

## Information about indemnity insurance

The NMC recommends that a registered nurse or midwife, in advising, treating and caring for patients/clients, has professional indemnity insurance. This is in the interests of clients, patients and registrants in the event of claims of professional negligence.

Although employers have vicarious liability for the negligent acts and/or omissions of their employees, such cover does not normally extend to activities undertaken outside the registrant's employment. Independent practice would not be covered by vicarious liability. It is the individual registrant's responsibility to establish their insurance status and take appropriate action.

In situations where an employer does not have vicarious liability, the NMC recommends that registrants obtain adequate professional indemnity insurance. If unable to secure professional indemnity insurance, a registrant will need to demonstrate that all their clients/patients are fully informed of this fact and the implications that this might have in the event of a claim for professional negligence.

## Appendix 1.2

### Guidance on professional conduct for nursing and midwifery students

Source: reproduced with permission Nursing and Midwifery Council (2010) ([www.nmc-uk.org](http://www.nmc-uk.org))

### The four core principles of the code

Your conduct as a nursing or midwifery student is based on the four core principles that we've set out in the code:

- 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 wellbeing 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

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

You should:

1. Treat people as individuals and respect their dignity
2. Be polite, kind, caring and compassionate
3. Not discriminate in any way against those for whom you provide care
4. Recognise diversity and respect the cultural differences, values and beliefs of others, including the people you care for and other members of staff

Respect a person's confidentiality

You should:

5. Respect a person's right to confidentiality
6. Not disclose information to anyone who is not entitled to it
7. Seek advice from your mentor or tutor before disclosing information if you believe someone may be at risk of harm
8. Follow the guidelines or policy on confidentiality as set out by your university and clinical placement provider
9. Be aware of and follow the NMC guidelines on confidentiality (available from our website [www.nmc-uk.org](http://www.nmc-uk.org))
10. Make anonymous any information included in your coursework or assessments that may directly or indirectly identify people, staff, relatives, carers or clinical placement providers
11. Follow your university and clinical placement provider guidelines and policy on ethics when involved or participating in research

Collaborate with those in your care

You should:

12. Listen to people and respond to their concerns and preferences
13. Support people in caring for themselves to improve and maintain their health
14. Give people information and advice, in a way they can understand, so they can make choices and decisions about their care
15. Work in partnership with people, their families and carers

Ensure you gain consent

You should:

16. Make sure that people know that you are a student
17. Ensure that you gain their consent before you begin to provide care
18. Respect the right for people to request care to be provided by a registered professional

Maintain clear professional boundaries

You should:

19. Maintain clear professional boundaries in the relationships that you have with others, especially with vulnerable adults and children
20. Refuse any gifts, favours or hospitality that might be interpreted as an attempt to gain preferential treatment
21. Not ask for or accept loans from anyone for whom you provide care or anyone close to them

22. Maintain clear sexual boundaries at all times with the people for whom you provide care, their families and carers
23. Be aware of and follow the NMC guidelines on maintaining clear sexual boundaries (available from the advice section on our website [www.nmc-uk.org](http://www.nmc-uk.org))

Work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community

Work as part of a team

You should:

24. Be aware of the roles and responsibilities of other people involved in providing health and social care
25. Work cooperatively within teams and respect the skills, expertise and contributions from all people involved with your education
26. Treat all colleagues, team members and those with whom you work and learn, fairly and without discrimination
27. Inform your mentor or tutor immediately if you believe that you, a colleague or anyone else may be putting someone at risk of harm

Provide a high standard of practice and care at all times

Recognise and work within your limits of competence

You should:

28. Recognise and stay within the limits of your competence
29. Work only under the appropriate supervision and support of a qualified professional and ask for help from your mentor or tutor when you need it
30. Work with your mentor and tutor to monitor the quality of your work and maintain the safety of people for whom you provide care
31. Seek help from an appropriately qualified healthcare professional, as soon as possible, if your performance or judgement is affected by your health

Ensure your skills and knowledge are up to date

You should:

32. Take responsibility for your own learning
33. Follow the policy on attendance as set out by your university and clinical placement provider
34. Follow the policy on submission of coursework and completion of clinical assessments as set out by your university and clinical placement provider
35. Reflect on and respond constructively to feedback that you are given
36. Endeavour to provide care based on the best available evidence or best practice

Keep clear and accurate records

You should:

37. Ensure that you are familiar with and follow our record keeping guidance for nurses and midwives (available from our website [www.nmc-uk.org](http://www.nmc-uk.org))
38. Ensure that you follow local policy on the recording, handling and storage of records

Be open and honest, act with integrity and uphold the reputation of your profession

Be open and honest

You should:

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39. Be honest and trustworthy when completing all records and logs of your practice experience
40. Not plagiarise or falsify coursework or clinical assessments
41. Ensure that you complete CVs and application forms truthfully and accurately
42. Ensure that you are not influenced by any commercial incentives

Act with integrity

You should:

43. Demonstrate a personal and professional commitment to equality and diversity
44. Abide by the laws of the country in which you are undertaking your programme and inform your university immediately if, during your programme, you are arrested or receive any caution or warning or similar sanction from the police
45. Inform your university if you have been cautioned, charged or found guilty of a criminal offence at any time
46. Ensure that you are familiar with and abide by the rules, regulations, policies and procedures of your university and clinical placement provider
47. Abide by UK laws and the rules, regulation, policies and procedures of the university and clinical placement providers with regard to your use of the internet and social networking sites
48. Ensure that you are familiar with and follow our advice on the use of social networking sites (available from our website [www.nmc-uk.org](http://www.nmc-uk.org))

Protect people from harm

You should:

49. Seek help and advice from a mentor or tutor when there is a need to protect people from harm
50. Seek help immediately from an appropriately qualified professional if someone for whom you are providing care has suffered harm for any reason
51. Seek help from your mentor or tutor if people indicate that they are unhappy about their care or treatment

Uphold the reputation of the nursing and midwifery professions

You should:

52. Follow the dress code or uniform policy of your university and clinical placement provider
53. Be aware that your behaviour and conduct inside and outside of the university and clinical placement, including your personal life, may impact on your fitness to practise and ability to complete your programme
54. Uphold the reputation of your chosen profession at all times