**Evidence & practice/ CPD/ duty of care**

**Organisational knowing**

**[title] Understanding and meeting your legal responsibilities as a nurse**

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**Abstract**

Nurses, midwives and students are legally responsible for their actions. This article discusses the legal standard of care in relation to nursing and midwifery practice and the Nursing and Midwifery Council Code. It examines how the courts determine if nurses have met their duty of care and how nurses must ensure they maintain competence in order to provide safe care. It examines why organisational knowing is important for all nurses, regardless of their level in the organisation. Workplace incivility is discussed and its adverse effects on nurses, patient care and the organisation. The article concludes that if nurses are uncertain why they are doing something, they must investigate further. The law expects nurses to be able to justify why they acted as they did, or failed to act.

**Keywords**

clinical negligence, competence, duty of care, legal responsibility, Nursing and Midwifery Council, nursing student, organisational knowing, patient safety, registered nurse, standards of care, workplace incivility

**Aims and intended learning outcomes**

This article aims to develop nurses’ understanding of their legal responsibilities and how knowing the organisation in which they are employed or on placement helps meet the legal standards expected of them. After reading this article and completing the time out activities you should be able to:

* Discuss the legal standard of care in relation to your practice and The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing and Midwifery Council (NMC) 2015).
* Identify how legal responsibilities alter with the transition from nursing student to qualified nurse.
* Discuss how organisational knowing is important for all nurses, regardless of their level in the organisation.
* Identify workplace incivility and discuss its adverse effects on nurses, patient care and the organisation.

**Relevance to The Code**

Nurses are encouraged to apply the four themes of The Code to their professional practice (NMC 2015). The themes are: Prioritise people, Practise effectively, Preserve safety, and Promote professionalism and trust. This article relates to The Code in the following ways:

* It states that workplace incivility is not acceptable. The Code requires nurses to prioritise people by treating them with kindness, respect and compassion and challenging any discriminatory attitudes and behaviours.
* It encourages nurses to seek and welcome feedback to improve their practice. The Code requires nurses to practise effectively by gathering and reflecting on feedback.
* It enables nurses to preserve safety by exploring the importance of working in the limits of their competence and raising concerns immediately whenever they come across situations that put patients or public safety at risk.
* It states nurses must continue to update their knowledge and skills to remain competent. The Code requires nurses to promote professionalism and trust by keeping their knowledge and skills up to date.

**Time Out 1**

**Have you read the latest edition of The Code (NMC 2015)? If not, this is a good place to start. Look at Table 1 to understand how you can make links between examples of legal responsibilities in The Code and the ideas in this article.**

**Introduction**

Nursing and midwifery practice combines personal and professional aspects as nurses are judged by the intent and consequences of their actions. This partly explains why much of The Code (NMC 2015) relates to the legal responsibilities of registered nurses and midwives (Table 1).

Involvement in other people’s lives carries risk. In 2016-17, the Department of Health’s (DH) provision for existing or potential clinical negligence claims was £60 billion (National Audit Office 2017). In addition to the financial cost, injured patients or clients may suffer physical and psychological harms that money cannot cure. Few practitioners intend to harm anyone and so their involvement in an incident may cause feelings of guilt or inadequacy. They may experience physical and psychological consequences even if they do not face financial sanctions because, usually, compensation is paid by the employer not the negligent employee. This is because the employer is vicariously liable for the negligent acts or omissions of their employee. Vicarious liability applies as long as the employee is working within the terms and scope of their employment. All NHS Trusts in England belong to the Clinical Negligence Scheme for Trusts (<http://www.nhsla.com>) which handles clinical negligence claims on behalf of their Trust members. The fewer claims against a Trust, the lower their contribution fees to the Scheme. Despite awareness of threats to patient safety, organisations, and the people in them, may place nurses in situations where they fail to meet their legal responsibilities. This is why in 2016 the DH added human factors, that is, how a human interacts with processes, systems, equipment and the environment, questions to the Serious Hazards of Transfusion database (Dendrite) for reporting transfusion near-misses or incidents (Watt 2017). Questions in Dendrite ask the person reporting to identify, on a scale of 0 to 10, where 0 is none and 10 is the total cause, the extent to which the incident was caused by unsafe:

* Practice by individual member(s) of staff.
* Conditions associated with the local environment or workplace.
* Conditions related to organisational or management issues in the trust or health board.
* Conditions associated with the government, DH or high-level regulatory issues.

These questions indicate how legal responsibilities are not just personal, but entwined with colleagues’ responsibilities, the workplace, the organisation and external rules and regulations. Many Trusts use Datix, a cloud-based information analysis system that not only captures reports of incidents or adverse outcomes but facilitates exploration of the underpinning reasons, including human factors, so that strategies to prevent recurrences can be implemented, assessed and evaluated continuously.

**Legal responsibilities**

Nurses, midwives and students are accountable for the care that they provide or should have provided. To bring a successful claim of negligence in law, it is necessary to prove that the:

1. Patient was owed a duty of care by the defendant.
2. Defendant (doctor, nurse or hospital) breached the duty of care by failing to reach the standard required of them by law. The breach can be an act done poorly or an omission to do something that should have been done.
3. Breach caused harm: expert witnesses will advise the court on causation.
4. Harm was of a type that was foreseeable: expert witnesses will assess foreseeability**.**

Our involvement with others is complicated as the duty of care exists the moment that the patient or client presents for treatment or care. This even applies to rendering first aid to a stranger in the street. In Caparo Industries plcv Dickman [1990] UKHL 2, the House of Lords, now the Supreme Court, introduced a three-stage test to determine whether the person was owed a duty of care, of whether there is:

1. Proximity between the defendant and the claimant.
2. Foreseeability of harm.
3. It is fair, just and reasonable to hold there is a duty of care.

‘Proximity’ may exist even when the nurse is no longer with the patient. For example, if the patient has been discharged, gone to another ward or the nurse has left the client’s house. Others base their actions, such as the care they give or treatment they prescribe, on the records made by the nurse, so any harm that occurs is foreseeable and it is reasonable to hold that a duty of care continues.

Not all involvement is equal so the law recognises that different standards of care should be expected in different circumstances. The courts judge the standard of care using the test set out in the case of Bolam v Friern Hospital Management Committee [1957] 1 WLR 582: ‘the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest skill...It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.’ The Bolam test was criticised for allowing doctors to escape legal responsibility for their negligent acts or omissions, therefore Bolitho v City and Hackney HA [1998] AC 232 established that practice and decisions must be evidence based. Your nursing actions must reflect the skill expected of your role and they have to be justifiable in accordance with research-based evidence. Other nurses may say they would have done the same as you but that does not mean you have met the standard the law expects.

The key words in the Bolam test are exercising and professing:

* Professing is what you say you are: healthcare assistant (HCA), nursing associate, nursing student, newly qualified nurse, midwife, charge nurse, doctor, manager or chief executive.
* Exercisingis what you do: what task were you actually doing?

Both terms apply otherwise this might suggest that if care is carried out by someone who professes to be less qualified, a lower standard of care would be acceptable. The NHS is a training organisation, not just a healthcare provider. To avoid people refusing to be treated by less qualified staff or by trainees the same standard of competent care is required, regardless of who provides it. In Nettleship v Weston[1971] 3 WLR 370 it was held that the learner driver and instructor together had to meet the standard of an ordinary competent driver although not the higher standard of the instructor. In a nursing context, the nursing student and mentor together must meet the legal standard of an ordinary competent nurse, that is, a qualified nurse. If an error occurs, the registered nurse would be professionally liable but the student will not as they have not yet been admitted to the NMC register.

**Time out 2**

**Using the concepts of exercising and professing consider how the legal and professional responsibilities differ between being a healthcare assistant, a supernumerary nursing student or a qualified nurse. Think about different tasks in your clinical area and consider who might perform those tasks. How might legal and professional liability be different? For example, if a catheter is inserted, a nursing student would be doing this under supervision of a mentor. Some students will be healthcare assistants seconded by their NHS Trust. If they are working as an HCA, their trust might have trained and approved them to insert catheters but if they are on the ward as a student, they might have the skill to insert the catheter safely but they might not yet have been signed off in their placement pack as a student to do this.**

Being newly qualified does not reduce the level of responsibility. In Wilsher v Essex AHA[1988] AC 1074 a junior doctor made errors caring for a premature baby. The baby received too much oxygen, suffered retrolental fibroplasia and was left blind. The doctor’s inexperience was no excuse. However, he met his standard of care because he recognised his inexperience and called on a senior doctor to check his work. The senior doctor was at fault because he failed to notice the errors. If a registered nurse delegates nursing activities to an HCA, the nurse has a duty to ensure those activities are carried out competently. Otherwise the nurse might ‘adopt’ the error of the person to whom the task was delegated, as with the senior doctor in the Wilsher case. The NMC 2015-16 Fitness to Practice Report included a case where an allegation was made that a nurse had delegated tasks to a junior nurse that were beyond her capabilities (NMC, 2016). Most NHS organisations have a period of preceptorship for newly qualified nurses to help them make a smooth transition from being a student to a registered nurse (Department of Health, 2010). The standard of care goes with the post – the Wilshercase tells us this. So, on day one as a newly qualified nurse, the standard applied is that of a qualified nurse. When the nurse is promoted to a higher band or specialist post, many organisations have descriptors for each band. On day one in a higher band, the standard applied is that of an ordinary competent nurse in that band.

**Time out 3**

**There are now roles that mix employment and learner status. If you are a nursing associate or a nursing apprentice, reflect on how you will be working in your organisation as an HCA some days and on others as a nursing student. How might your different roles affect your legal responsibilities?**

Nurse and midwives increasingly complain that they have insufficient time for adequate care. Missed care is a growing concern as it counts as an omission. Research in the US identified that 73% of nurses reported missing at least one care activity during their last shift (Lake et al 2016). Even higher levels of undone work, including not updating nursing care plans, were reported by nurses in a UK study by Ball et al (2014). Minimum nurse-patient staffing ratios are legally binding in several American states, unlike the UK. In April 2018, Wales will become the first country within the UK where there will be minimum nurse-patient ratios. The Nurse Staffing Levels (Wales) Act 2016 will initially apply to adult acute wards and employers will have a duty to take ‘reasonable steps’ to maintain nurse staffing levels (<http://www.legislation.gov.uk/anaw/2016/5/section/1>). There are no plans yet to extend this to the whole of the UK. Nurses must remember that they owe a duty of care to each patient. They cannot owe half a duty of care because the ward is short-staffed and they have twice the number of patients to look after. Nurses need to know what the organisational process is if faced with a short-staffed shift, including how to escalate their concern and who has the authority to request bank or agency staff to cover shifts. It is also important that the nurse completes any organisational reporting documentation, for example, via Datix.

**Advice-giving**

Nurses are also providers of advice to patients and clients, a role that will be heightened in the forthcoming NMC standards for pre-registration nursing education. Legal liability can arise if poor advice is given. In the CaparocaseLord Oliver explained when a duty of care arises in relation to advice. Nurses or midwives will owe a duty of care if:

* They provided advice to someone.
* They knew, or should have known, that the advice would probably be followed.
* They knew, or should have known, the person receiving the advice would not check that the advice was correct.
* The person who acted on that advice suffered some harm as a result.

Nurses should consider the advice they give to patients, families, clients, colleagues and students. Advice from a nurse will probably be acted on as most people trust nurses and may not check if the advice is sound (Rørtveit et al 2015). A 2015 American study found that newly qualified nurses often defer to the advice of experienced nurse colleagues, even when they know the advice given contradicts evidence-based practice (Krautscheild et al, 2015). If your patient relies on your poorly given advice and suffers harm, you are legally responsible for that harm. If your student follows your advice and a patient is harmed, you and the student have legal responsibility. The greater responsibility, possibly the sole responsibility, will lie with the registrant.

Once the nurse has been shown to have failed to meet the standard of care, whether by act or omission, establishing if ‘foreseeable harm’ has occurred will be determined by expert witness evidence. Sometimes, the scientific evidence is too uncertain to make the causal link or the harm was not foreseeable at the time. The birth defects caused by thalidomide were ‘unforeseeable’ at the time. In such situations, a negligence claim would fail and no compensation would be paid. However, the nurse would still have failed in their legal responsibilities and may face disciplinary action by the employer or the NMC. Nurses and midwives who are accused of negligence cannot act as expert witnesses in their own defence. Their best defence is to ensure they are practising competently.

**Time out 4**

**Reflect on some recent care you delivered. Was it competent? What situations threatened patient care? How involved were you? Consider your responsibility – do you think you did everything you should have done at the time or afterwards?**

**Ensuring competence**

The legal term ‘competence’ differs from the practical competencies that all nurses and midwives must demonstrate to gain registration. In determining if the standard of care has been met, the law assesses if people have demonstrated competence and incompetence in the performance of their work. A competency model has been developed that can be used as part of a training needs analysis. This framework has been attributed to Howell (1982), drawing on Appelbaum et al’s (1981) research into capacity to consent to psychiatric hospitalisation. Whatever the competence, the person could fall into any one of four categories. The authors have developed the framework further so it reflects nursing practice (see Figure 1):

* Unconsciously incompetent. A new nursing student might fall into the unconsciously incompetent category. A new student told her personal tutor that when she worked as a care assistant a patient she looked after had her legs bandaged by the district nurse. After the district nurse had left, she would re-bandage the patient’s legs as ‘the lady would complain they were too tight’. The student proudly said the patient told her what a good nurse she would be.
* Consciously incompetent. Eventually, this student would learn the concept of compression bandaging and at that point she would hopefully recognise her former unconscious incompetence and move into the next category of consciously incompetent.
* Consciously competent. At some point, the student’s skills and knowledge of compression bandaging would be assessed and on passing this ‘competency’, she would be consciously competent. Here, she would still be thinking about her skills and double-checking that she had everything right.
* Unconsciously competent. In time, a nurse might move into the category of unconsciously competent where it is no longer necessary to do the mental checklists and performance is polished and fluid.

The best nurses act competently even under the most urgent of pressures. However, organisational pressures can mean that even good nurses are at risk of missing something which is why early warning systems, for example, for sepsis, are useful. The Royal College of Physicians (2012) developed a National Early Warning Score to help improve the assessment of and response to acute illness.

A danger exists, however, that without constant reflection, the nurse’s practice may slip into unconscious incompetence again. This may be what happened in the case of James Wisheart, the heart surgeon whose practice at Bristol Royal Infirmary was highly praised for many years. When it came to a particular type of children’s heart surgery he was unable to recognise that he was less than competent. Compared with similar surgical units, 30 to 35 more babies and infants died during 1991-1995 than would have been expected. Many more were brain-damaged. The Kennedy Report (2001) into these events was the first of a series into failures of care in the NHS. Practice is personal and professional: there is a risk that some nurses’ psychological make-up means they see themselves as experts and everyone else as incompetent (Kruger and Dunning 1999). Kruger and Dunning (1999) noted that such people are generally much less competent than they believe. Unconscious incompetence poses a high risk to patients since the nurse is practising unsupervised.

Maintaining awareness of your level of competence is the most effective way to guard against your practice becoming less than competent. The law case that gave us the Bolam test makes it clear that it is negligent to ‘obstinately and pigheadedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed…opinion’. Thus, nurses must continue to update their professional knowledge and skills.

**Time out 5**

**On your next day at work, consciously reflect on the care you have given. Use the competency model in Figure 1 to explore your own competence and identify your position in the figure on a variety of nursing practice skills.**

Reflective practice enables nurses to maintain competence much better than relying on their subconscious processing. The Code expects nurses to use reflection as part of revalidation (NMC 2015). Getting into the habit of reflecting on your performance, after every episode of care or every shift, helps to make conscious the unconscious.

The Code expects nurses to gather and reflect on feedback to improve their practice (NMC 2015) and to be prepared to give ‘honest, accurate and constructive feedback to colleagues’ (NMC 2015). Kruger and Dunning (1999) explain that too often the incompetent fail to learn from their errors because no one tells them about their incompetence.

As trust in organisations erodes (Francis 2013), organisations put in place ever more rules and systems (O’Neill 2002). People can feel so swamped by the number of rules, protocols or policies that they fail to keep up to date with them. Even if you can honestly say that you did not see the latest memo or email about a new policy, guideline or system to follow, the law will hold you to have ‘constructive knowledge’. In other words, if an ordinary competent nurse would have known, you will be deemed negligent for not knowing and for not following the policy. This applies even if you are working as an agency or bank nurse. It may be the first time that you have worked in an organisation, but your ignorance of its policies, protocols and systems is no defence in law. Therefore, it is good practice for clinical areas to have up-to-date information easily available for agency or bank staff. In the clinical area someone should be responsible for ensuring that this resource is kept up to date. These are aspects of ‘organisational knowing’.

**Time out 6**

**What policies, protocols and guidelines, including organisational, national or royal college, relate to your practice area? When are they due to be reviewed? If they are out of date and you simply follow them what consequences may this have for your competence?**

**Organisational knowing**

To ensure competent care or provision of advice, standardisation has occurred in the form of guidelines, protocols and policies which organisations expect their staff to follow. However, they need to be updated regularly in line with emerging new evidence. They can be used as evidence in a court of law: failure to comply with standard guidance may be seen as proof of failure to meet the relevant standard of care.

The use of guidelines was explored in the case of C (by his father and litigation friend) v North Cumbria University Hospitals NHS Trust [2014] EWHC 61 where the mother died and the baby was severely brain-damaged. The midwife had followed the existing guidelines and was cleared of negligence. The lack of clarity in the guidelines was identified: they were ‘not complete or comprehensive’. Nurses must do more than simply follow guidelines: they have a legal and professional responsibility to critically appraise the quality of guidelines, protocols and policies.

The courts have made it clear that guidelines are only guidelines. If departure from them can be justified, for example because more recent evidence has emerged, it would be wrong to ‘slavishly follow’ them (see the Bolithocasementioned earlier)*.* This also applies to national guidance like the code of practice (Department for Constitutional Affairs 2007) accompanying the Mental Capacity Act 2005.In the Court of Protection case,The Mental Health Trust & Another v DD & Another [2014] EWCOP 11, Mr Justice Cobb said: ‘Plainly the Code provides valuable Guidance. That is what it is – “Guidance”, and if the circumstances of the case dictate an alternative view, then I should not regard myself bound to follow the Guidance in preference.’

It is important to check the dates on guidelines, protocols and policies. Even National Institute for Health and Care Excellence guidelines can become outdated because new research has been published since they were issued. The Care Quality Commission (CQC) (2015a) quality report into Whipps Cross University Hospital was particularly critical of the absence of evidence that national clinical guidelines were being used. The CQC has found similar organisational failures elsewhere and placed Trusts in special measures as a result. The special measures process aims to provide support to improve for NHS Trusts that have serious failings in their quality of care. Since July 2013 when special measures started, 31 NHS Trusts have entered the process and, by the end of July 2017, 16 have exited because they had achieved sufficient improvement (CQC 2017a).

Across the UK, healthcare organisations are undergoing change, often related to ‘austerity’ or cuts in government funding. Patient care suffered badly at Mid-Staffordshire NHS Foundation Trust, in part because of nursing shortages and an organisational focus on managing budgets (Francis 2010). For example, patients were left in soiled sheets for hours as supplies had run out and there were insufficient staff to change the beds in any case. Francis (2010) warned: ‘…safe and consistent care cannot be delivered unless change is properly planned and risk assessed, with proper engagement of the staff whose duty it is to deliver that care. Finance, in the sense of the resource made available to the Trust, must always be the servant of the Trust’s purpose – the delivery of good and safe care – and not the master which dictates the standard of delivery, however poor.’ In other words, accepting a situation that you know is wrong cannot be justified on the grounds of budgetary restraints.

When newly qualified nurses join an organisation, they want to fit into the team (Maben et al 2006). This means that they are at risk of adopting the ward’s existing culture and practices. Dufresne et al (no date) observed that if novices get ‘the right answer for the wrong reason’ they feel rewarded and continue to apply the wrong approach. Overseas nurses, who may be experiencing the stress of transition to a different country and healthcare system, might also fail to question practice differences and see them as ‘just another adaptation to make’. Nurses need to develop their ‘organisational knowing’ to avoid such pitfalls (Terry and Carr 2017).

Administrative activities, often a consequence of the systems imposed to try to ensure organisations and staff meet their legal responsibilities, take up a large amount of a nurse’s day. If every nurse, midwife or student, particularly those new to an organisation or ward, took the time to understand the organisation, avoidable threats to patient welfare such as relying on out-of-date guidelines or adding to the burden of other wards by taking their pillows could be reduced. Nurses need to learn how to operate successfully in organisations. This means learning ‘how’ and ‘who’. How do they order replacement cartridges for the printer to avoid delays in discharging patients? Who is responsible for ensuring policies are up to date and complied with? How can they access training if they identify a need without feeling embarrassed? Who will address the poor performance of a colleague?

Halpin, Terry and Curzio (2017) argue that ‘without knowing the organization within which they practice, nurses can feel powerless, frustrated and trapped…or develop unquestioning acceptance of the status quo’. The CQC (2015b) report on Mersey Care NHS Foundation Trust noted that on the rehabilitation unit, ligature cutters were locked in a cupboard that only some staff could access (http://www.cqc.org.uk/provider/RW4/inspection-summary#mhlongstay). On revisiting, the CQC (2017b) noted that all staff could access ligature cutters, staff had been properly trained and objective ligature risk assessments were conducted by staff from another area. However, asking ‘who has the key?’, ‘how do we get access to the key when those staff are absent?’ and ‘how acceptable is this situation?’ could have resulted in a change to the status quo and improved care before the CQC visited. Box 1 gives examples of organisational knowing.

**Time out 7**

**Reflect on how well you know your organisation. What organisational factors can you identify that affect safe patient care? Do you know who to go to if you have concerns about patient safety, workplace incivility, your need for training or any other aspects related to your employment or the purpose of the organisation?**

**Workplace incivility**

Organisations with poorly performing areas often have staff shortages and poor organisational culture (Francis, 2010). This may result in nurses feeling drained, undervalued and stressed, which in turn can lead to unacceptable behaviours towards colleagues. Participants in Halpin, Terry and Curzio’s (2017) research suggested that bullying was rife, which can lead to loss of morale and nurses leaving their jobs or even the profession.

Nurses must ‘treat people with kindness, respect and compassion’ (NMC 2015) and this applies as much to colleagues as it does to patients or clients. In relation to patient safety and public protection, they must ‘not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff…who wants to raise a concern’ (NMC 2015). The reputation of the profession must be upheld at all times including acting ‘without discrimination, bullying or harassment’ (NMC 2015) or causing people ‘upset or distress’ (NMC 2015).

Andersson and Pearson (1999) defined workplace incivility as: ‘*...* low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. Uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others.’

A key feature of incivility is behaviour that is low-intensity, yet results in ‘harmful emotional consequences’ (D’Ambra and Andrews 2014). Nurses being uncivil towards other nurses, newly qualified nurses and nursing students; doctors being uncivil towards nurses; and HCAs being uncivil towards nurses have all been identified as workplace occurrences. Why incivility occurs has long been speculated, for example, the workplace consisting of different generations of nurses (Boychuk Duchscher and Cowin 2004) and an unequal distribution of power (Roberts et al 2009). However, workplace incivility can have severe effects on the individual and organisation in terms of poor physical/mental health and poorly functioning teams. Halpin, Terry and Curzio (2017) found that newly qualified nurses who were the recipients of uncivil actions reported greater work-related stress. Box 2 provides some examples of uncivil behaviour.

**Time out 8**

**Have you encountered workplace incivility? If so, reflect on why people behaved in an uncivil manner. What was the underlying cause? What are you going to do about that incident or incidents? How will you stop yourself being uncivil to others in the future?**

**Conclusion**

Nurses need to maintain their competence in order to provide safe patient care. They need to understand the organisations in which they are working and play their part in ensuring the organisation provides high-quality patient care by, for example, knowing where to find the information needed, considering when policies, guidelines and protocols were written and if they need revising and who to go to if anything needs to be addressed. They need to be alert to potential threats to patient or client safety or to themselves and their colleagues and know what to do about risks they identify. They need to maintain a professional demeanour at all times including towards colleagues. Uncivil behaviour is not acceptable and must be addressed. Box 3 identifies behaviours consistent with The Code (NMC 2015).

The most important question for any nurse to ask is why am I doing this? If you are uncertain why, you need to investigate further as the courts will expect you to be able to justify why you acted as you did, or failed to act.

**Time out 9**

**Nurses are encouraged to apply the four themes of The Code (NMC 2015) to their professional practice. Consider how understanding and meeting your legal responsibilities as a nurse relates to The Code.**

**Time out 10**

**Now that you have completed the article you might like to write a reflective account as part of your revalidation.**

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**Table 1: Examples of legal responsibilities in The Code**

|  |
| --- |
| Section |
| Challenge poor practice | 3.4 |
| Get properly informed consent | 4.2 |
| Respect people’s right to privacy and confidentiality | 5 |
| Practise in line with the best available evidence  | 6 |
| Evaluate the quality of your work and that of the team | 8.4 |
| Preserve the safety of those receiving care | 8.5 |
| Identify and reduce risk | 8.6 |
| Keep clear and accurate records | 10 |
| Be accountable for your decisions to delegate tasks and duties to other people  | 11 |
| Recognise and work within the limits of your competence  | 13 |
| Act immediately to put right the situation if someone has suffered actual harm…or an incident has happened which had the potential for harm  | 14.1 |
| Escalate any concerns | 16.1 |
| Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations  | 18 |
| Be aware of, and reduce as far as possible, any potential for harm associated with your practice | 19 |
| Keep your knowledge and skills up to date  | 22.3  |

(Nursing and Midwifery Council 2015)

**Box 1: Examples of organisational knowing**

* How and where to find copies of guidelines, policies, protocols, regulations or systems that are relevant to the clinical practice area
* How to access library databases subscribed to by the organisation
* How to raise concerns about patient safety, safe working conditions or outdated guidelines, policies or protocols
* Who’s who in the organisation
* How the chain of command operates
* How to act on and report uncivil behaviour
* How the organisation’s staff appraisal system works
* How to obtain organisational support for continuing professional development activities
* How to handle situations where you feel you are being asked to act outside your level of competence

**Box 2 Examples of workplace incivility**

* Hurtful comments such as ‘don’t you know how to do that?’ or ‘why can’t you do that?’
* Refusing to help someone when you reasonably could
* Belittling someone in front of others
* Not listening to both sides of a story
* Repeatedly criticising someone instead of finding ways to help them
* Talking about someone in less than positive terms
* Trying to provoke someone
* Eye-rolling
* Treating someone as if they are invisible
* Nicknames that hurt someone’s feelings

**Box 3: Behaviours consistent with The Code (NMC 2015)**

**Prioritise people**

* Be professional not uncivil
* Challenge poor practice
* Ensure you understand your legal obligations regarding consent, confidentiality and other laws relating to your field of practice

**Practise effectively**

* Keep your knowledge and skills up to date
* Be alert to new risks or problems arising and know how to address them
* Ensure you know organisational requirements including policies and guidelines relevant to your area of clinical practice
* Ensure you can justify your acts, including any advice you provide, and omissions
* Evaluate the quality of your work and that of your colleagues through giving and receiving honest, constructive feedback

**Preserve safety**

* Practise reflectively so you ensure you are working competently and within your limits
* Be risk-aware and know what steps to take in your organisation to address incidents or issues that may cause harm
* Ensure you are following the most recent guidelines, policies or regulations
* Appraise current guidelines, policies and protocols to ensure that they are still valid or if recently-published research evidence means that they need to be changed
* Know what steps to take in your organisation if guidelines, policies or protocols need altering

**Promote professionalism and trust**

* Be civil to others and know how to tackle any incidents of incivility in your organisation
* Act as a role model for students, newly qualified nurses and others
* Engage in continuing professional development and reflection to ensure you are competent in every aspect of your practice