Legal responsibility and accountability

Chris Cox looks at risk management and accountability issues for nurses, especially those undertaking extended roles

Summary

Shifting boundaries in healthcare roles have led to anxiety among some nurses about their legal responsibilities and accountabilities. This is partly because of a lack of education about legal principles that underpin healthcare delivery. This article explains the law in terms of standards of care, duty of care, vicarious liability and indemnity insurance.

Keywords

Law, ethics, legal responsibility, accountability, liability, duty of care, education

As the working boundaries between healthcare practitioners shift, with registered nurses taking on many of the tasks previously undertaken by medical colleagues, and healthcare support workers assuming responsibility for activities traditionally performed by registered nurses, issues of risk management and legal accountability inevitably arise.

Questions typically raised by practitioners, their colleagues and their managers in a perpetually moving healthcare environment concern whether:

- They will be held responsible by a court for their actions.
- It is legal for them to undertake certain work.
- They retain accountability for tasks even though they have delegated them to others properly.
- They need separate insurance or indemnity arrangements for extended roles.

Such uncertainty reflects a gap in education about the legal principles that underpin the delivery of healthcare. In fact, the answers to these questions are reasonably straightforward.

First, the law generally does not prescribe who might perform particular healthcare tasks or roles, although there are exceptions. Under mental health legislation, for example, only doctors are empowered to perform certain compulsory mental healthcare procedures. But these exceptions are limited and the general rule applies to most healthcare interventions.

Even if the law is not prescriptive in the identification of who can do what in healthcare, it nevertheless provides a regulatory framework for how this care should be delivered in practice.

This is realised through the ordinary principles of civil, or common, law, known as the law of tort, and, in particular, the law of negligence. Although both criminal and contract law are also relevant, neither are as significant as the ordinary principles of negligence law and are therefore not considered further in this article.

Appropriate standards

The law imposes a duty of care on practitioners, whether healthcare support workers, registered nurses, doctors or others, in circumstances where it is ‘reasonably foreseeable’ that they might cause harm to patients through their actions or their failure to act.

‘Public policy’ might dictate that no legal duty of care should arise, despite the risk or actuality of harm. For example, there is generally no duty to ‘rescue’ someone in danger, so health professionals are not legally required to act as good Samaritans. But it can be guaranteed that, once healthcare workers assume responsibility for the care of patients, they owe them a legal duty of care.

This applies whether they are performing straightforward tasks such as bathing patients or undertaking the most complex forms of surgical intervention. In each instance, it is obvious that, if they act carelessly, they may injure patients.

Once the law imposes a duty of care, the key question concerns what standard of care is expected of practitioners performing particular tasks or roles. And this is the source of the uncertainty and confusion for many healthcare practitioners and their managers in relation to the broadening or enhancing of traditional nursing and other roles.
Consider this issue from the patients’ perspective. It is obvious that every patient should be entitled to expect a similar standard of care in relation to a particular healthcare intervention, irrespective of where, when and by whom the care is delivered.

Incidentally, I am addressing here only a situation where it is accepted that a particular investigation or treatment should be undertaken or given, and not where there is dispute about whether it can be afforded or is a clinical priority.

To use an analogy, when we drive on the roads, we expect that other road users observe the same legal standard of care in terms of road safety, observance of the Highway Code and so on, irrespective of who is driving the other vehicle and how long ago they learnt to drive.

In the context of health care, the law imposes a standard of care in relation to each task and this standard applies no matter where patients receive treatment and irrespective of their carers’ qualifications. ‘Inexperience’, for example, is therefore generally not a defence to claims of negligence. The legal standard of care is judged by that of the ‘ordinarily competent practitioner’ performing the particular task or role. This was established as long ago as 1957 in the case of Bolam v Friern Hospital Management Committee.

In other words, the evidence of a practice universally adopted by a responsible, relevant and reasonable body or appropriate practitioners usually determines the standard that courts accept as appropriate in the circumstances. Should healthcare practitioners fall below this standard, they breach their duty of care; if they observe this standard, they do not breach their duty of care, even if the patient suffers harm.

In relation to certain tasks, the courts can simply apply common sense in determining the relevant standard and not require expert testimony. Poor handwriting on a prescription or in a patient record, for example, or a failure to read the relevant patient notes or to check the temperature of the water before bathing a patient, are inexcusable by the standards of any reasonable person.

However, other tasks, such as taking note of signs and symptoms, or the tests or treatments that ought to be undertaken or given, are matters of professional judgment and necessitate expert advice from responsible practitioners. In other words, courts generally defer to the relevant healthcare professionals to determine appropriate standards of care. A summary is given in Box 1.

The summary in Box 1 illustrates that there are no unique legal issues presented by the extension or enhancement of traditional nursing or other roles, and practitioners should have no worries.

None of the above will be new to many registered nurses because they will immediately recognise the requirements of the Nursing and Midwifery Council (NMC) code of professional conduct (NMC 2008) and the documents that are aimed at explaining or illustrating individual provisions of the code.

Duty of care
A duty of care can be owed to the same patient by several individuals and the healthcare organisation itself. The care professional who performs a particular task is said to owe a direct, or primary, duty of care to the patient.

Furthermore, where the task has been delegated to the care professional by a more experienced practitioner, on whom the overall responsibility for providing care to the patient initially fell, the experienced practitioner may also owe a direct duty of care to the patient to ensure appropriate delegation. Guidance on delegation for registered nurses is given in the NMC code, and mirrors the advice of other care professional bodies to their registrants.

Finally, the organisation employing the care professional may also owe a direct duty of care to the patient and be liable for what are often described as ‘systemic errors’, such as a fault in the system it has for training and supervising staff, or having too few staff.

Vicarious liability
Employing organisations can also be ‘vicariously liable’, however, for the actions of their employees. This is known as secondary liability.

Some people think that employers can choose to accept or decline their responsibilities but, where an employee was acting ‘in connection with’ his

---

**Box 1 Standards of care**

- The law does not generally prescribe who can perform a particular healthcare task or role.
- The law does, however, insist that there is a standard of care in relation to each task or role that applies generally, irrespective of who performs it.
- If healthcare practitioners extend or develop their roles, they must be confident that, in accepting responsibility for a patient’s care, they have the knowledge, skills and experience to perform the task or role required of them to the requisite legal standard. From a risk management perspective, this is surely the only real issue.
or her employment when he or she caused harm to a patient, the employer is without question vicariously liable for his or her actions (Lister v Hesley Hall Ltd [2002]).

Employers have to appreciate this, particularly when they invite staff to change their roles. The onus is on employers to ensure that staff are trained and supervised properly until they can demonstrate their competence in new roles and work to appropriate standards of care.

Nurses occasionally ask whether new tasks or roles must be recorded in their contracts of employment or job descriptions before their employers are vicariously liable for their actions, or inaction.

So, after a nurse qualifies as an independent prescriber, for example, is the employer liable for the nurse’s actions in prescribing for patients only once it is written into the contractual documentation?

The answer is no. In approving, expressly or by implication, that the nurse undertakes prescribing, the employer is responsible for his or her actions.

In practice, however, it makes sense to record in writing the full extent of your extended role, not least because this is important for evaluating the demands of the job for grading and other purposes.

**Indemnity insurance**

Developing or extending roles can also cause uncertainty about the relevance of indemnity insurance or contractual indemnity arrangements covering potential claims of clinical negligence or those made under public liability.

Where employers are vicariously liable for the actions of their staff, they need to have insurance to cover the risks of clinical negligence claims arising from employee carelessness. Individual practitioners should take out insurance to cover any risks associated with their clinical practice.


For details of the NHS Litigation Authority’s Clinical Negligence Scheme for Trusts, visit http://tinyurl.com/385kyob

**Conclusion**

I end with a plea. At the beginning of this article, I alluded to a continuing gap in the education of many healthcare practitioners, including medical practitioners, physiotherapists, pharmacists and others, about the legal and ethical implications of their clinical practice. This is particularly apparent in relation to legal accountability, standards of care, consent and confidentiality.

Much of the uncertainty and confusion arising from changes in the management of healthcare delivery, and the development of ‘new nursing roles’, would be eliminated or minimised if employing organisations and relevant educational bodies plugged this gap with appropriate multiprofessional training.

**Further reading**


For details of the NHS Litigation Authority’s Clinical Negligence Scheme for Trusts, visit http://tinyurl.com/385kyob

**References**

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118

Lister v Hesley Hall Ltd [2002] 1 AC 215