Accountability and legal issues in tissue viability nursing

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Summary
Avoidable pressure ulcers are being increasingly used as an indicator of substandard care. Healthcare professionals may have to account for their actions when a pressure ulcer occurs. This article highlights accountability and legal issues that nurses may encounter when caring for patients with wounds and, in particular, pressure ulcers.

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Accountability
Registered nurses and midwives are accountable both professionally and legally under the following laws (Royal College of Nursing (RCN) 2008):

- Civil law – nurses and midwives have a duty of care to the public to ensure that they come to no harm while in their care. Cases of negligence can result from poor care.
- Criminal law – nurses and midwives have a duty within criminal law to refrain from causing any intentional harm to patients. Accusations of assault can lead to a criminal prosecution.
- Employment law – nurses and midwives have a duty to work within the guidelines and policies provided by their employer. Any actions outside of these guidelines that cause harm to patients will result in a loss of vicarious liability (the employer will no longer be legally responsible for the actions of its employees).

Unregistered staff, for example clinical support workers, are accountable legally but not professionally, as they are not registered by a regulatory body such as the Nursing and Midwifery Council (NMC).

The NHS is spent an estimated £2.3-3.1 billion in 2005/06 on wound and pressure ulcer management (Posnett and Franks 2007). Delivering wound care can take up much of a nurse’s time, particularly in the community setting (Drew et al 2007, Haworth 2009). The complexity of wound healing can be underestimated by patients. Subsequently, when healing is delayed or problems occur, the patient may blame the healthcare professional. Equally, patients can underestimate the severity of wounds, and in particular that of pressure ulcers. Poor communication and a lack of understanding on the patient’s part can increase the incidence of complaints (Abraham 2008). This article explores legal and accountability issues in relation to wound and pressure ulcer management.

WOUND MANAGEMENT and the prevention of skin breakdown are key aspects of tissue viability nursing. Almost all nurses will have some contact with patients who have wounds that need to be managed. It is essential that nurses develop a broad and expansive knowledge of skin care and pressure ulcer risk assessment, prevention and management, as well as wound healing. It is necessary to understand the range of dressings and bandages available for use in wound management, as well as the wide variety of equipment available to help prevent pressure ulcer formation. Nurses need to feel confident that they are making the right treatment decisions with and for patients, and that this is based on the best available evidence. It is vital that all treatment decisions and care provided are documented to provide evidence in potential legal proceedings; there is anecdotal evidence that such documentation may improve patient care and prevent complaints.
The NMC is responsible for maintaining the register of suitably qualified and competent nurses and midwives (NMC 2010a). In doing this, the council safeguards patients’ health and wellbeing by reassuring them that the person caring for them is competent and safe to do so and is working to a code of conduct (NMC 2008a). Clinical support workers are at present unregulated by a professional body, although the NMC is researching the practicalities of registering this large section of the healthcare workforce (NMC 2010b). However, regardless of title, qualification or rank, all healthcare staff are accountable in law for any actions or omission of actions that directly result in harm caused to the patient in their care.

The NMC uses the civil standard of proof to determine fitness to practice (NMC 2009). This means that an NMC conduct and competence committee has to be persuaded that, more likely than not, a nurse’s fitness to practise has been impaired. In 2008/09, around 30% of allegations made to the NMC reached a conduct and competence committee (NMC 2009). Allegations that may relate to tissue viability nursing include (NMC 2009): lack of competence, failure to maintain records, neglect of basic care, failure to communicate and failure to obtain consent.

**Delegation**
The role of the nurse has evolved over the last century from ‘doctor’s handmaiden’ (Jones and Davies 1999, Birch 2001) to performing traditional medical tasks (Ball 2005). The expansion of the nurse’s role has come about partly in response to the need to reduce the working hours of junior doctors (Birch 2001, Pickersgill 2001) as a result of the European Working Time Directive (Department of Health 2010). For example, nurses are now involved in cannulation, administering intravenous medication and, in some specialist and advanced roles, more invasive procedures such as upper and lower gastrointestinal endoscopies (Ball 2005, Williams et al 2009). This expansion of the nurse’s role has ultimately led to the devolution of some tasks and nursing skills to clinical support workers. Within the realms of professional and legal accountability a nurse must ‘recognise and work within the limits of their own competence’ (NMC 2008a). They must also ensure that any task delegated to a clinical support worker is reasonable, within his or her scope of training and in the best interests of the patient in his or her care (NMC 2008b). This means that professional accountability for the delegated task or skill remains with the registered nurse.

Skills for Health (2007) provides clearly defined competencies to ensure that differing levels of staff undertake acceptable and appropriate tasks within the realms of their competency. However, there are several aspects of care that clinical support workers might be performing in tissue viability that raise concerns about competency and accountability (Box 1).

**Competency**
CHS 1.2 considers wound care (Skills for Health 2007). This is an aspect of care that is increasingly being undertaken by clinical support workers. Registered nurses need to ensure that the clinical support worker has had adequate training in the wound care task and has demonstrated competence. Competency in changing a routine surgical wound dressing is not the same as competency in performing dressing changes to a deep cavity wound. This wide difference between wound types, and the level of expertise needed to undertake wound management, has prompted debate about the involvement of clinical support workers in some aspects of wound care (Hampton 2002, 2004, Anderson 2004, Shepherd 2004).

Assessment is a nursing skill and nurses have the professional accountability to ensure safe assessment of patients. Wound assessment is therefore carried out by registered nurses. However, with the correct competency training, attitude and support, a clinical support worker may be expected to perform wound care safely. How far their role extends is a matter for local debate and consideration. The registered nurse must remember, however, that they ‘retain responsibility and accountability for the delegation’ (NMC 2008b). Clearly written local guidance, based on national guidelines, and competency frameworks around wound care and pressure ulcer management will safeguard the patient, the clinical support worker and the registered nurse delegating the wound care task.

**Negligence and documentation**
It is rarely the intention of any healthcare professional to cause harm to patients. However, a person may seek damages in accordance with civil law for negligence where there has been a breach in the duty of the care given by the healthcare provider, resulting in harm (Fullbrook 2008). For the purpose of this article, the issue of neglect is discussed with regard to the development of pressure ulcers. It is important to note that, while it is not possible to state how many pressure ulcers are unavoidable, there is developing consensus that for some

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**Box 1**

**Activities that clinical support workers may be undertaking without adequate competency training or support**

- Application of compression bandaging in a clinical setting or in the patient’s home.
- Application of topical negative therapy dressings.
- Application of larval therapy.
- Assessment of patients at risk of developing pressure ulcers.
- Grading of a pressure ulcer.
groups of patients pressure ulcers may be an inevitable event (Theaker et al 2003, National Pressure Ulcer Advisory Panel 2010).

Approximately 21% of general hospital patients may have a pressure ulcer (Clark et al 2002). Posnett and Franks (2007) estimated that 410,000 people may have developed a new pressure ulcer in 2000. They also estimate that one in 2.3 people aged over 65 years will have developed a pressure ulcer (Posnett and Franks 2007). If a patient develops a pressure ulcer at home, and he or she was not known to the healthcare team, it is unlikely that any healthcare professional would be held accountable for this development. In contrast, if a patient recovering from abdominal surgery in hospital develops a pressure ulcer five days after surgery, it could be argued that this should not have happened and the patient may decide to proceed with litigious activity.

Clinical negligence claims are on the increase, although less than 4% of cases make it to court (NHSLA). Between 2003 and 2008, approximately £2.75 million was awarded to more than 100 claimants for damages involving pressure ulcers (Sarah Nicholson, NHSLA, London, 2008, personal communication). Nurses have a duty of care to patients that includes preventing harm caused by pressure ulcers. Other care providers, such as nursing homes or NHS hospitals, must also uphold this duty. National guidance (NICE 2005) should be adapted locally so that staff have clear pathways to follow that assist them in delivering preventive care.

Pressure ulcers are now being recognised by the DH (2009a) as an avoidable incident and will be included as a nursing quality outcome indicator. The NHS Institute for Innovation and Improvement (2010a) has produced a ‘high impact action’, which aims to prevent avoidable pressure ulcers in NHS-provided care. Primary care trusts may soon be able to withhold payments when pressure ulcers develop in other institutions (DH 2009a).

One proposed definition of an avoidable pressure ulcer is one that occurs 72 hours after admission to a healthcare setting (NHS Institute for Innovation and Improvement 2010b). However, some pressure ulcers that develop within the healthcare setting after this time (Iglesias et al 2006) may be deemed unavoidable (National Pressure Ulcer Advisory Panel 2010). In these circumstances, documentation may need to be provided as evidence that all preventive care processes and measures were taken to prevent the ulcer from developing. Box 2 outlines key features in line with national guidance (NICE 2003, 2005, 2009) that would need to be included in this documentation. To support nursing staff, their employers must provide education on pressure ulcer prevention guidelines and documentation.

**Safeguarding vulnerable adults**

It has been reported that the development of pressure ulcers can lead to safeguarding vulnerable adults investigations (DH 2009b). There may be local guidance to support the investigation of possible neglect following the development of a pressure ulcer (Vowden et al 2006). In these circumstances, the pressure ulcer has been viewed as a direct result of neglect or a breach of duty of care.

Pathologists and undertakers may report pressure ulcers to the coroner. The coroner’s main role is to investigate the cause of death. One of the several verdicts he or she may find is neglect; another is death by natural causes (Chapman 2005). In the case of pressure ulcers contributing to death, the coroner will need to investigate the circumstances leading up to the development of the pressure ulcer. He or she will attempt to determine whether the pressure ulcer was unavoidable or if there was a breach in the duty of care. To ascertain whether a pressure ulcer was unavoidable, the coroner’s request may rely on staff interviews, documentation, national guidance and outcome measure definitions. If negligence is determined as a causative factor in the development of the pressure ulcer and the patient’s subsequent death, the coroner can refer the case to the Crown Prosecution Service (Dimond 2005) and a police investigation will commence (Chapman 2005).

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**BOX 2**

**Evidence to be included in all documentation**

- Risk assessment on admission and ongoing risk assessment.
- Skin inspection.
- Pressure reducing or relieving equipment used.
- Preventive care planning.
- Patient information leaflets and communication.
- Repositioning schedules.
- Referrals to other professionals or specialist nurses.
- A photograph or tracing of developed ulcers.
- Removal of anti-embolism stockings for heel inspection.
- Wound assessment and management plan.
- Support surface used in operating theatres.
- Clinical incident reporting.

Mental capacity and consent

Mental capacity

The issue of consent cannot
be considered without reference to the Mental Capacity Act 2005, which came into force in
2007 and is relevant to those over 16 years of age in England and Wales. The act provides an
assessment structure to guide healthcare professionals in determining which of their
patients have the capacity to make decisions, even though the healthcare professional may not
understand or agree with the decision (Dimond 2007) and even if the decision may lead to life
threatening outcomes. Capacity must be assessed in every case in relation to the particular decision
being made (DH 2009c). If lack of capacity is determined then any treatment or investigation
must be carried out only in the best interests of the patient. Box 3 highlights the main principles
of the Mental Capacity Act 2005.

Patients receiving tissue viability-related care
need to demonstrate capacity to agree to many
aspects of their treatment. These aspects include
routine procedures such as changing a dressing,
removing clips, assessing and applying compression
bandaging, the use of a pressure-
relieving mattress and positional changes.

Consent

‘It is a general legal and ethical principle
that valid consent must be obtained before
starting treatment or physical investigation,
or providing personal care’ (DH 2009c). Consent
is an important issue and it is essential that all
healthcare professionals are familiar with
relevant guidance (DH 2009c). Touching a
patient without consent may constitute an offence
of battery (NMC 2008c). If harm is caused to a
patient and valid consent (Box 4) has not been
obtained, then the professional may be accused of
negligence (NMC 2008c, DH 2009c). Poor
handling of the consent process may lead to
complaints (Abraham 2008).

Consent can be given in a number of ways,
including verbally, by implication and in writing.
Written consent, while not required legally in most
cases, is deemed to be good practice, particularly
for interventions such as surgery (DH 2009c). It is
evidence that informed, valid consent was given,
but is not evidence of continued consent (DH
2009c). Consent can be withdrawn, verbally, at
any time. Obtaining written consent for all actions
and care interventions would clearly be
inappropriate. However, assuming implied
consent just because someone is in hospital or
has allowed a professional into his or her home
can pose a risk to the healthcare professional.
Documenting verbal consent for care
interventions is good practice (Dimond 2001).

It is essential that staff are familiar with their
local, professional and national guidance on
consent. They must use appropriate consent forms

Where concerns are raised about safeguarding
vulnerable adults, referral should be made to the
Independent Safeguarding Authority, which is
responsible for the Vetting and Barring Scheme
(Home Office 2010). A nurse may be added to the
barred list if he or she is deemed to have failed to
protect a vulnerable patient. Nurses can help to
safeguard their patients, their registration and
their livelihoods by following national and local
guidelines and accurately documenting the risk
assessments and care provided.

BOX 3
Main principles of the Mental Capacity Act 2005

Assume capacity unless lack of capacity has been established.

A person is not to be treated as unable to make a decision unless all
practicable steps to help him or her to do so have been taken without
success.

A person is not to be treated as unable to make a decision merely
because he or she may make an unwise decision.

An act carried out, or a decision made, under the Mental Capacity Act
2005 for or on behalf of a person who lacks capacity must be done in
his or her best interests.

Before the act is carried out, or a decision is made, consideration of
alternatives less restrictive to the person’s rights and freedoms must
be made.

BOX 4
Constituents of valid consent

Should be given voluntarily.

Should be fully informed.

Should be provided without coercion.

Should be given with an understanding of the nature and purpose
of the treatment.

Does not depend on the form in which it is given.

Should be sought by the professional undertaking the procedure. If
delegated to another, this person must be suitably trained or qualified.

TABLE 1
Examples of situations where consent may be needed

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<thead>
<tr>
<th>Verbal</th>
<th>Written</th>
<th>Implied</th>
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<tr>
<td>Use of larval therapy</td>
<td>Photography</td>
<td>Positional changes</td>
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<tr>
<td>Use of topical negative pressure therapy</td>
<td>Sharp debridement</td>
<td>Dressing change and wound assessment</td>
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<tr>
<td>Dressing change and wound assessment</td>
<td>Biopsy</td>
<td>Use of pressure-relieving devices</td>
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where they are provided. Table 1 contains examples of where different types of consent may need to be gained in tissue viability, which may differ according to local practice and guidelines.

Conclusion

All registered nurses and midwives are accountable professionally and legally for their actions or omissions. They should ensure they are competent for the task they are undertaking or delegating, have assured competency of all staff undertaking delegated tasks and have obtained valid consent for the care they are providing. Following national, professional and local guidance is essential if nurses are to safeguard their patients and their professional registration.

References


