Nurses' Roles and Responsibilities

Throughout this piece, the nurses' roles and responsibilities within care provision in a hospital-based environment will be critically analysed with support from relevant literature and guidelines from regulatory bodies. This topic has been selected as McInnes, Peters, Bonney and Halcomb (2017) highlight that understanding of the nurses' role has seemingly diminished as staff have admitted to performing tasks not typically associated with their role or level of responsibility. The rationale for this will be explored throughout this piece and recommendations for practice will be offered.

A fundamental aspect of the nurses' role outlined within 'The Code' (Nursing and Midwifery Council, (NMC), 2015) is to provide high-quality care that is individualised to the patients' specific needs. This has become one of the most important principles that guide care; as extensive research illustrates that specialised plans and care, adapted to the needs of the individual have positive impacts on patient experience and long-term recovery (Riding, Glendening and Heaslip, 2017). Furthermore, Goggins, Wallston, Mion, Cawthon and Kripalani (2016) emphasise that it is nurses who are typically responsible for gathering information about patients who have been admitted; as they are considered to be the professionals with the most direct patient contact. To achieve person-centred care, it is important that nurses establish an effective therapeutic relationship with the patient to ensure that they attain an accurate account of their specific needs. Brownie, Scott and Rossiter (2016) state that this can be encouraged by ensuring that both effective verbal and non-verbal communication is adopted as this will promote trust and openness. Furthermore, by employing non-verbal communication approaches such as active listening, this can facilitate a more holistic assessment as the patient will feel included within care provision and may be more likely to share information relating to their care (Tamirisa et.al, 2017). This strategy is

strongly supported by the Department of Health (DoH: 'No decision about me, without me', 2012) who insist that all healthcare practitioners must engage with patients in a way that promotes inclusivity to improve the patients' experience and enhance the provision of high-quality, person-centred care. Although, Green, Oeppen, Smith and Brennan (2017) highlight that the perceived hierarchy within healthcare could diminish the patients' willingness to engage in care decisions, particularly if they feel powerless to their condition. These feelings can be exacerbated by practitioners' use of medical jargon which is still surprisingly prevalent within healthcare (Thomas, Hariharan, Rana, Swain and Andrew, 2014). In recognition of this, it is imperative that nurses understand their role within practice to actively encourage the patient to engage in their care, partially by improving patients' understanding of their condition and minimising the use of medical jargon.

Whilst collaborating with patients is an integral aspect of the nurses' role, it is essential not to overlook the importance of also collaborating with family or carers of the patient, particularly if the individual receiving care has compromised mental capacity (Barry and Davies, 2006). Schulz and Martire (2004) highlight how beneficial it can be to involve patients' relatives or carers within care provision as it can reduce the patients' feelings of isolation and institutionalisation. Although, Etters, Goodall and Harrison (2008) stress that involving relatives can also exacerbate feelings of being a burden and, in some instances, can create conflict if relatives disagree over the terms of care. This can be incredibly challenging for the patient, relatives and healthcare professionals and it is the nurses' role to encourage family engagement in a way that will compliment the patients' experience. Additionally, it is important for the nurse to recognise that involving the family should not replace patient involvement, as Livingston et.al. (2010) highlight, this is common within healthcare, particularly in elderly medicine and dementia services. To rectify this issue and enhance the nurses' approach, training courses specialised to these areas are recommended as part of

development training. Although, Ross, Barr and Stevens (2013) identified that many hospital nurses are failing to undertake required training due to the time constraints and pressures on wards which could undoubtedly influence the quality and safety of patient care. Therefore, it is also imperative that all nurses recognise the importance of completing additional training once qualified, regardless of possible barriers, to ensure that their skills and knowledge are up-to-date and relevant to patient care.

The NMC also emphasise that working collaboratively within the Multi-Disciplinary Team (MDT) is an integral aspect of the nurses role, particularly as patients are now presenting with more complex needs that require extensive input from a variety of health and social care professionals (Ndoro, 214). By working effectively with the MDT, this could enhance the provision of holistic, person-centred care as more services could be offered from a variety of disciplines that will promote the patients long-term recovery (Johnson, 2013). A prime example of this would be care provision for a patient following a stroke. Once admitted, nurses conduct a comprehensive and holistic assessment of the patients' needs and level of impairment. The patient is often then referred for inpatient physiotherapy to increase mobility, speech and language therapy to minimise dysphasia and occupational therapy to promote independence for hospital discharge. As these professionals from a variety of disciplines often work across many departments, it is the nurses' role to coordinate suitable times for each of the professionals within the MDT to see the patient, in addition to ensuring that all medication and personal care is attended to. Furthermore, it is often the nurses' role to communicate progress and needs between members of the MDT as they are most likely to be available for handover on a ward. Failure to collaborate effectively within the MDT could have a significant impact on the patients long-term recovery as needs could be miscommunicated which could drastically diminish the quality of care provision (Daly, 2004).

A fundamental responsibility of the nurse is to ensure that all care provision is underpinned by the principles of the NHS Constitution and the 6 C's (Smolowitz et.al, 2015). This is supported by the NMC who encourage nurses to illustrate the values of: compassion, courage, communication, competence, commitment and care as this will enhance quality of care. By implementing the 6 C's, this could also have a profound impact on the development of a therapeutic relationship as the values are consistent with both professionalism and compassion (McEvoy and Duffy, 2008). In response to the Francis Report (2013), the nurses' responsibility to act with courage has been largely focused on. The investigation into failings at the Mid-Staffordshire hospital found that some nurses did not report poor quality practice. This was largely considered to be due to lack of support when whistle-blowing which has since been improved to encourage all staff to escalate concerns that would compromise patient safety or wellbeing (Dyer, 2015). Nevertheless, Moore and McAuliffe (2012) discovered that many nurses still feel reluctant to whistle-blow through fear of losing their job. It is imperative that this issue is addressed as raising concerns about poor quality practice has become an integral responsibility of the nurse (Duffy, McCallum, Ness and Price, 2012). Ensuring that adequate support is given to nurses highlighting bad practice could also enhance safeguarding for patients as the risk of harm could be reduced. Furthermore, appropriate whistle-blowing can demonstrate courage to challenge individuals or organisations that are not beneficial to patient care. This could have a positive effect on the care provision and strengthen the reputation of the Nursing profession (Gallagher, 2010).

The nurses' responsibility to consistently practise safely and effectively is reiterated by all healthcare governing bodies and is arguably one of the most important aspects of Nursing (Gluyas, 2015). In order to achieve this, nurses must ensure that their practice is evidence-based and up-to-date. This can be enhanced through regular training and committing to ongoing professional development that supports the notion of lifelong learning (Laal and

Salamati, 2012). In addition to regular training to enhance competence, an essential responsibility of nurses is to ensure that they recognise their own limitations within practice. Nancarrow et.al. (2013) suggest that this is one of the most effective ways to promote patient safety as it ensures that tasks are performed by professionals who are adequately trained and have the required level of competence. Although, Ball, Murrells, Rafferty, Morrow and Griffiths (2013) highlight that many nurses admit to performing tasks that are not typically related to their role or level of responsibility due to the current pressures within the NHS. This is particularly prominent amongst newly qualified or junior nurses who admit to having less confidence to decline a task or delegate to someone more suitable (Cipriano, 2010). However, regardless of experience or pressure from other colleagues, it is imperative that nurses only perform tasks they have been trained to complete competently to minimise patient risk and promote safety (Mueller and Vogelsmeier, 2013). Furthermore, the NMC reiterate that all nurses are professionally and personally accountable for their actions within practice and that errors could result in dismissal from the NMC register; emphasising the importance of consistently practising safely and effectively (Krautscheid, 2014).

Another important responsibility of nurses that is occasionally overlooked is documentation. It is imperative that patient care is fully accounted for within care plans. Beach and Oates (2014) highlight that it is common for nurses to become complacent with documentation, particularly if they are responsible for looking after the same patients. Whilst documentation is immensely time consuming, particularly for patients with complex needs, it is important to fully document all interactions as this will benefit other health professionals involved in care provision (Dehghan., Dehgan., Sheikhrabori., Sadeghi and Jalalian, 2013). Additionally, thorough documentation can support accountability and enhance the nurses' reputation in the instance of litigation (Owen, 2005). Although, interestingly, Prideaux (2013) highlighted that some nurses admit to feeling nervous about documenting serious incidents such as falls or

deterioration through fear of being held responsible. However, it is important to recognise that the purpose of documentation is not to assign blame, but to provide a thorough account of factors that influence care provision. Furthermore, duty of candour relies on open and honest documentation to support the process of the patient receiving high-quality care and being aware of things that have gone wrong (Griffith, 2015). To enhance nurses understanding of the importance of thorough and comprehensive documentation, it is important to regularly attend training and request feedback within the personal review with regards to how documentation can be improved, particularly as many trusts are currently in the process of moving paperless systems which will inevitably take some adjusting to (Onifade and Sque, 2016).

To conclude, this piece has critically analysed some of the fundamental roles and responsibilities of nurses practising within healthcare. It is apparent that the aspects of Nursing discussed throughout this piece can facilitate the provision of high-quality care and are largely dependent on nurses' understanding and acceptance of their privileged position as trusted healthcare professionals. It is imperative that all nurses underpin their practice with the principles of the 6 C's and NHS Constitution as this will encourage development of therapeutic relationships and enhance delivery of holistic, person-centred care.

This piece has demonstrated that high-quality care provision within a hospital relies upon well-trained staff who use evidence-based practice to guide person-centred and compassionate care. Additionally, the importance of collaborative working with the patient, relatives and MDT cannot be overlooked as this facilitates the provision of holistic care that promotes long-term recovery and enhances the patients' experience.

It is important to question whether, as previously stated, nurses lack understanding of their roles and responsibilities as this piece has illustrated nurses often perform tasks outside of

their role due to the demands of Nursing during a time when NHS trusts are under-resourced and poorly funded. This is inevitably compromising daily Nursing practice and must be addressed if high-quality care provision is to be promoted and achieved within healthcare services. However, it is important to acknowledge that this is not the sole reason for nurses performing tasks not typically associated with their role or level of responsibility; illustrating that the core aspects of nursing duties need more clarity.

Reference List:

- Ball J.E., Murrells T., Rafferty A.M., Morrow E. & Griffiths P. (2013). Care left undone during nursing shifts: associations with workload and perceived quality of care. BMJ Quality and Safety, 7-8.
- Barry A. & Davies S. (2006). Moving forward together: evaluation of an action group involving staff and relatives within a nursing home for older people with dementia. International Journal of Older People Nursing, 1(2), 95-104.
- Beach J. & Oates J. (2014). Maintaining best practice in record keeping and documentation. Nursing Standard, 28(36), 45-50.
- Brownie S., Scott R. & Rossiter R. (2016). Therapeutic communication and relationships in chronic and complex care. Nursing Standard, 31(6), 54-61.
- Cipriano P. (2010). Overview and Summary: Delegation dilemmas: standards and skills for practice. The Journal of Issues in Nursing, 15(2), 9-12.
- Daly G. (2004). Understanding the barriers to multiprofessional collaboration. Nursing Times, 100(9), 78.
- Deghan M., Deghan D., Sheikhrabori A., Sadeghi M. & Jalalian M. (2013). Quality improvement in clinical documentation does clinical governance work? Journal of Multidisciplinary Healthcare, 6(1), 441-450.

- Department of Health. (DoH, 2012). Liberating the NHS: no decision about me, without me. [Date accessed: February 2018] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216980/Liberating-the-NHS-No-decision-about-me-without-me-Government-response.pdf
- Duffy K., McCallum J., Ness V. & Price L. (2012). Whistleblowing and student nurses – are we asking too much? Nurse Education in Practice, 12(4), 177-178.
- Dyer C. (2015). Francis report recommends a whistleblowing guardian in every NHS organisation. British Medical Journal, 350(1), 82-88.
- Etters L., Goodall D. & Harrison B.E. (2008). Caregiver burden among dementia patient caregivers: a review of the literature. Journal of the American Association of Nurse Practitioners, 20(8), 423-428.
- Gallagher A. (2010). Whistleblowing: what influences nurses' decisions on whether to report poor practice. Nursing Times, 106(1), 4.
- Gluyas H. (2015). Effective communication and team work promotes patient safety. Nursing Standard, 29(49), 50-57.
- Goggins K., Wallston K.A., Mion L., Cawthon C. & Kripalani S. (2016). What patient characteristics influence nurses' assessment of health literacy? Journal of Health Communication, 21(2), 105-108.
- Green B., Oeppen R.S., Smith D.W. & Brennan P.A. (2017). Challenging hierarchy in healthcare teams. The British Journal of Oral and Maxillofacial Surgery, 55(5), 449-453.
- Griffith R. (2015). The duty of candour: what it means for practising nurses. British Journal of Nursing, 24(21), 10-12.
- Johnson J.E. (2013). Working together in the best interest of the patient. Journal of the American Board for Family Medicine, 26(3), 241-243.

- Krautscheid L.C. (2014). Defining professional nursing accountability: a literature review. Journal of Professional Nursing, 30(1), 43-47.
- Laal M. & Salamati P. (2012). Lifelong learning: why do we need it? Social and Behavioural Sciences, 31(1), 399-403.
- Livingston G., Leavey G., Manela M., Livingston D., Rait G., Sampson E.,. Bavishi S., Shahriyarmolki K. & Cooper C. (2010). Making decisions for people with dementia who lack capacity: qualitative study of family carers in the UK. British Medical Journal, 341(1), 41-84.
- McEvoy L. & Duffy A. (2008). Holistic practice: a concept analysis. Nurse Education in Practice, 8(1), 412-419.
- McInnes S., Peters K., Bonney A. & Halcomb E. (2017). A qualitative study of collaboration in general practice: understanding the general practice nurses' role. Journal of Clinical Nursing, 26(13), 1960-1968.
- Mid-Staffordshire NHS Foundation Trust Public Inquiry. (2013). The Francis Report. [Date accessed: February 2018] Available at: http://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffspublicinquiry.com/report
- Moore L. & McAuliffe E. (2012). To report or not to report? Why some nurses are reluctant to whistleblow. Clinical Governance: An international Journal, 17(4), 332-342.
- Mueller C. & Vogelsmeier A. (2013). Effective delegation: understanding responsibility, authority and accountability. Journal of Nursing Regulation, 4(3), 20-27.

- Nancarrow S.A., Booth A., Ariss S., Smith T., Enderby P. & Roots A. (2013). Ten principles of good interdisciplinary team work. Human Resources for Health, 20(13), 11-19.
- Ndoro S. (2014). Effective multidisciplinary working: the key to high-quality care. British Journal of Nursing, 23(13), 72-74.
- Nursing and Midwifery Council (NMC, 2015). The Code. [Date accessed: February 2018] Available at: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
- Onifade A. & Sque M. (2016). Views on and perceptions of a paperless NHS. Nursing Times, 112(32), 12-14.
- Owen K. (2005). Documentation in nursing practice. Nursing Standard, 19(32), 48-49.
- Prideaux A. (2013). Issues in nursing documentation and record-keeping practice. British Journal of Nursing, 20(22), 68-69.
- Riding S., Glendening N. & Heaslip V. (2017). Real world challenges in delivering person-centred care: a community based case study. British Journal of Community Nursing, 22(8), 391-396.
- Ross K., Barr J. & Stevens J. (2013). Mandatory continuing professional development requirements: what does this mean for Australian nurses. BMC Nursing, 12(9), 9-12.
- Schulz R. & Martire L.M. (2004). Family caregiving of persons with dementia: prevalence, health effects and support strategies. The American Journal of Geriatric Psychiatry, 12(3), 240-249.
- Smolowitz J., Speakman E., Wojnar D., Whelan E.M., Ulrich S., Hayes C. & Wood L. (2015). Role of the registered nurse in primary health care: meeting health care needs in the 21st century. Nursing Outlook, 63(2), 130-136.

- Tamirisa N.P., Goodwin J.S., Kandalan A., Linder S.K., Weller S., Turrubiate S., Silva C. & Riall T.S. (2017). Patient and physician views of shared decision-making in cancer. Health Expectations, 20(6), 1248-1253.
- Thomas M., Hariharan M., Rana S., Swain S. & Andrew A. (2014). Medical jargon as hinderence in doctor-patient communication. Psychological Studies, 59(4), 394-400.