

# **Professionalism and accountability**

### **Key Message**

Professionalism and accountability is at the heart of patient care. As an Effective practitioner, the Codes and Standards that regulate the professions make it clear that each practitioner is personally accountable for their actions and omissions when dealing with patients, carers, family members and other members of the team. People in your care must trust you -- the codes and standards are there to ensure that the public are protected by competent practitioners.

There are 3 areas of accountability to be considered:

- 1. Personal: focusing on individual responsibility and awareness of your own competence and educational needs.
- 2. Team: focusing on issues such as delegation and the skill mix of staff to ensure that staff are prepared and supported to deliver the necessary care services assigned to the team.
- 3. Organisational: focusing on wider organisational issues such as having the appropriate policies, procedures, reporting and governance arrangements in place that includes for example whistleblowing and miscommunication.

The codes and standards outline the professional attributes and behaviours of the effective practitioner. In the current climate of intergration, it may be useful to familiarise yourself with the codes and standards of other professional within the multi-discplinary team. You'll find these within the signpost section,

#### What does this mean for the Effective Practitioner?

As a working practitioner you are personally accountable for your actions to your patients, colleagues, your regulatory body, your employer and the law. It is vital that you are clear about what accountability means to your practice and to address any learning and development needs in order that you can justify the decisions you make.



**Learning Activities** 





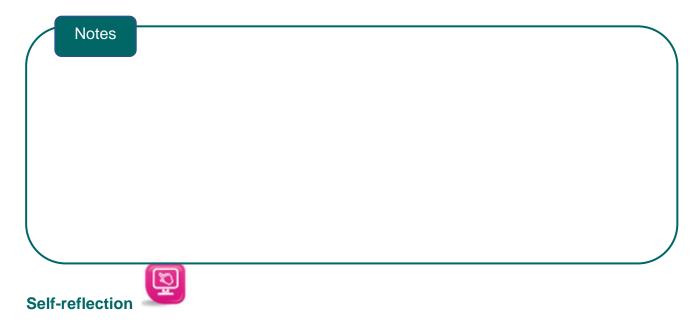
A critical incident is an event that has occurred in your workplace that has significantly influenced you or your colleagues. This could be negative or positive event involving a personal experience or an observation of colleagues at work. Analysing such an event can be an extremely useful learning experience. This involves closely examining the event and, through a process of reflection, using an evidence-based approach, identifying lessons to be learned. It is useful to do this with a colleague from your work place.

Identify a critical incident in your work place, which might raise concerns about one of the areas of accountability (i.e. personal, team, organisational).

- What happened?
- What were your thoughts?
- Where and when did it happen?
- Why did it happen?
- What were the positive and negative aspects of the incident?
- What was the outcome?
- What could have been done differently?
- What were the accountability issues?
- How did this relate to your Code/Standards of Practice (NMC or HPC)
- What action(s) were taken as a consequence of the incident?

Record your learning in your professional portfolio.

Related KSF core dimensions: personal and people development, service improvement and, quality





A critical incident is an event that has occurred in your workplace that has significantly influenced you or your colleagues. This could be negative or positive event involving a personal experience or an observation of colleagues at work. Analysing such an event can be an extremely useful learning experience. This involves closely examining the event and, through a process of reflection, using an evidence-based approach, identifying lessons to be learned. It is useful to do this with a colleague from your work place.

Identify a critical incident in your work place, which might raise concerns about one of the areas of accountability (i.e. personal, team, organisational).

- What happened?
- What were your thoughts?
- Where and when did it happen?
- Why did it happen?
- What were the positive and negative aspects of the incident?
- What was the outcome?
- What could have been done differently?
- What were the accountability issues?
- How did this relate to your Code/Standards of Practice (NMC or HPC)
- What action(s) were taken as a consequence of the incident?

Record your learning in your professional portfolio.

Related KSF core dimensions: personal and people development, service improvement and, quality



**Professionalism** 

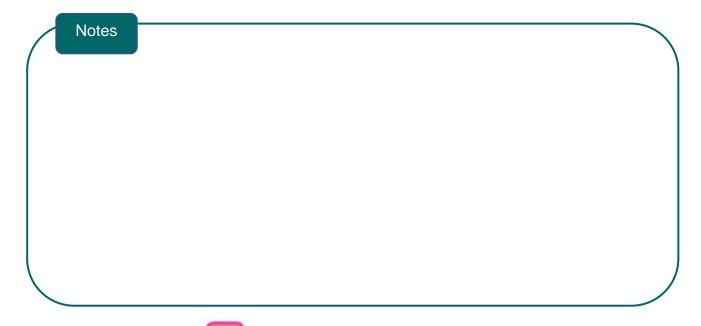


Public perception of the health professionals who are caring for them is usually positive and patients / clients have a good experience of the health service. Unfortunately, that is not always the case as you will be aware e.g. through complaints, ombudsman reports and some newspaper articles.

- Discuss with colleagues how your team act on negative feedback.
- Discuss with one or two of your patients what they consider are the attributes of an excellent health care professional.
- Reflect on how closely you and your colleagues match their description and if they would describe you in such terms.

Record your learning in your professional portfolio.

Related KSF core dimensions: communication, personal and people development and quality.



## The power of apology

The power of apology is an excellent communication tool that we can all use in our everyday practice. It's a way of enhancing relationships. It's a way of dealing with concerns and complaints at the time and it really is everybody's business. Apology is not about apportioning blame or being defensive, it's about being truly professional.

You might like to watch the video podcast (accessible on the right hand side of this page) where Dorothy Armstrong; Nurse Adviser to Scottish Public Services Ombudsman's office. talks about this simple but very effective tool. She also provides some case examples of how the tool can be used.



Even if you can't access the video try out the 4 R's for yourself.

If you find yourself in a situation where you're faced with someone who is clearly upset, distressed, angry, etc, then you can use the Power of Apology: we often find that immediately it can de-escalate the situation.

#### The 4 R's

- 1. REFLECT Stop, pause and think 'Can I help you?.'
- 2. REGRET Say sorry, unreserved, meaningful, genuine 'I am so sorry.'
- 3. REASON Explain, not defensive 'This is what happened.'
- 4. REMEDY -YOUR commitment to put things right, next steps. 'This is what I will do to prevent this happening again.'

Think about eye contact. Think about tone of voice. Think about your whole body language around the way that you're sitting or standing and all of that has a huge influence on the way that you communicate.

Reflect on your experience and consider how you might use this in your practice in future.

Related KSF core dimensions: quality; service improvement.

