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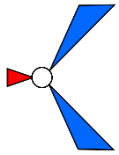
bncdoc.id	CHT
bncdoc.author	Morton-Cooper, Alison
bncdoc.year	1990
bncdoc.title	Returning to nursing. A guide for nurses and health visitors.
bncdoc.info	Returning to nursing. A guide for nurses and health visitors. Sample containing about 36640 words from a book (domain: social science)
Text availability	Worldwide rights cleared
Publication date	1985-1993
Text type	Written books and periodicals
David Lee's classification	W_non_ac_medicine

<1941/c>	nurse not only to be concerned with the outcome of the action but she must understand its origins and the process of carrying it out. Learners, for instance, may not be held **accountable**, because **accountability** implies knowledge, and it is unlikely that the learner will have acquired sufficient knowledge or have sufficient practical experience on which to base the assessment of the care given. The student may therefore be held responsible, but not **accountable**, for her actions, until she becomes sufficiently knowledgeable and experienced, and hence qualified. Burnard and Chapman go further-than this definition, by recommending that knowledge should be research based and up to date if it is to be the best for **accountability** in practice. In their book Professional and Ethical Issues in Nursing they carefully consider each clause of the Code of Conduct, and expand on its scope and implications. The authors see the requirement for the nurse to re-register every three years (periodic licensing), as an important step forward in ensuring 'that all patients receive the highest level of care and that the qualified nurse can really be seen to be in a position of **accountability'**. If we define **accountability** as 'being answerable' to someone for our actions, then to whom are we answerable? Even 10 years ago any nurse who was asked this question would probably have replied 'I'm answerable to sister.' Today the reality is just as straightforward, but may not be what a returning nurse might expect. The UKCC's global **accountability** is to the public on behalf of the professions. The nurse's individual **accountability** is to her patients first, but additionally to her managers, her employers and to her profession. Thus, where a conflict of interest exists between satisfying the wishes of the manager/employer and protecting the interests of the patient, your duty of care is to your patients first. This has raised far reaching and important issues of conscience since the Code was first published. Nurses are now encouraged to exercise their professional judgement in safe-guarding the interests of individual patients and clients, and for some this means exposing poor management and refusing to carry out instructions which they believe to be against the interests of their patients/clients. It can take a great deal of courage and confidence to challenge colleagues in this way, but as you will see by studying the Code itself, the definition and standards of conduct required are clear and unequivocal, even if putting them into practice is not always as easy as it is made to sound. Those of you who trained under a very autocratic system, dominated by a strictly imposed hierarchy where nurses came somewhere close to the bottom of the pyramid, are likely to find
 Key: **Footprint ConEn1** **Footprint ConEn2** **Footprint ConEn3**	**the concept of accountability**
	quite daunting. Whatever your length of time away from the bedside, however, the Code of Conduct enables us to make sense of **accountability**, and to assess its relevance to the settings in which we work. As Reg Pyne advises: 'In summary the portrait (Code) is of a practitioner who has the capacity to challenge, the honesty to ask why, the empathy to care, the skill to perform competently, and the determination not to be put down'. Copies of the Code, plus guidance on confidentiality and on advertising by registered nurses, midwives and health visitors,

	are available as advisory pamphlets from the UKCC. Tutors and mentors will wish to examine and introduce professional and ethical issues relating to the Code as and when opportunities present themselves. The references and further reading I have included here would make useful introductory reading to this subject and may help to prepare you for sessions and discussions based on the concept of accountability. The nature of stress in nursing A graphic account of the cumulative effects of too much stress experienced by nurses is given by Martin Bamber: A nurse under stress can not listen empathetically nor respond sensitively. Stress in the nurse can erode the nurse-patient relationship, or even act as a barrier to forming one. The quality of care provided by the nurse can be influenced by the levels of stress among the work force. While most of us would acknowledge that some level of stress is required to enable us to function and to be sufficiently motivated, the effects of continued high levels of stress have been shown to have a damaging effect on the ability to maintain our personal sense of purpose, usefulness and well-being. Bamber blames glamorised media portrayals of nurses for contributing to the problem in that they 'do nothing to support realistic expectations of working in a hospital, but only seem to strengthen the 'angel' stereotype'. As Bamber explains, such high expectations of the work, and an unrealistic idealism surrounding 'caring' and the medical model of illness, 'come crashing down with the reality of work experience'. Stress is a subject which has received a lot of attention and study in recent years. If we consider sources of stress as 'stressors' which build up to form a number of pressures, then it becomes possible to identify where stress is coming from and what it can ultimately lead us to. We can then begin to look for stress reducing and coping strategies to help alleviate the difficulties experienced in the everyday work situation. Potential stressors Looking at stress generally, and not necessarily as it affects nurses, the following might be considered as potential trouble spots: Transition and