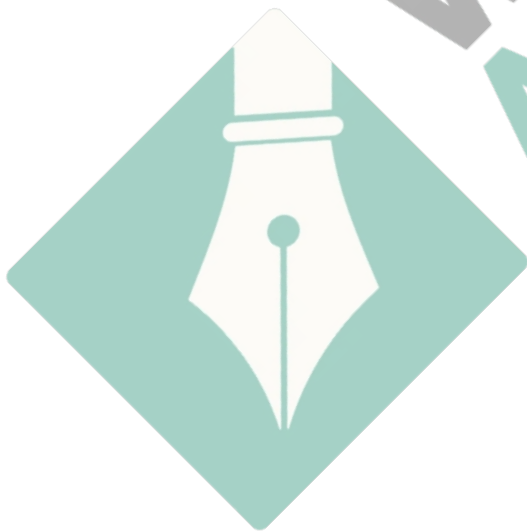


The Importance of Accountability in the Healthcare and Social Care
Practitioners



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Introduction

Over the years social and healthcare has changed significantly. During the beginning four decades of the National Health Service, accountability of the health care providers was solely to the patients and it followed a vague professional code of accountability. In its early years, the NHS allowed healthcare workers to practice their clinical skills with absolute freedom. However, in the mid-1980s, health and social workers became accountable for their services and expenses. This led to the documentation of rights of service users in the early 1990s. Evidence based medicine became a norm and guidelines were published on a number of diseases and patients during the years that followed. The guidelines of good practice and conduct were established in the years that followed. Health care and social practitioners were bound to meet the expected professional standards by professional regulatory bodies (Thompson et al., 2017). This has led to the requirement for clinicians to develop their knowledge, skills and use evidenced based clinical decision making in their practice. This would improve the quality of service provided by the NHS. These recent accountability models have revamped the interaction of health and social care workers with their patients, employers and clinical governance bodies (O'Grady et al., 2018). In this essay, we have discussed the definition of accountability in context with healthcare and social care workers, the areas within which they are held accountable and the importance of accurate record keeping to achieve higher quality care for patients.

Definition of Accountability

Accountability is defined as the professional responsibility of a health or social care worker for the quality of their work. Accountability is also defined as the standards of quality of work by the organisation they work for, the performance of the organisation and provision of service (Neby et al., 2017). Accountability also means to hold service providers for success and failure of service delivery according to professional standards (Persaud et al., 2019) . The incidents of health care service failure are quite rare in the UK. However, these incidents are extremely difficult for the public image of the NHS and the healthcare profession. The definition of accountability is to justify one's behaviour and be held responsible for it by a regulatory body. Professional regulatory agencies that monitor the accountability issues of health and social care workers, support the development of innovative solutions for patients at risk for such service failure incidents in the

future (O'Grady et al., 2018). In 1997, the National Health Service made accountability a duty of health and social care workers in the UK Green-Thompson, et.al (2017). Quality was no longer considered to be at the discretion of clinical and social managers or leaders. Clinical governance, social governance, accountability and quality of care become the statutory duty in the health and social care sector. The health care provider is held accountable for abiding by the highest standards in service delivery, for accurately evaluating the risk and challenges in healthcare service delivery and meeting the corporate goals of the organisation. The laws for clinical governance are sponsored by the Department of Health and Administration involved. The legal framework for regulatory control of health and social care workers. Government regulatory powers and parliamentary accountability for health care and social care service providers. It is the paramount duty of health and social care workers to safeguard and maintain the health and well-being standards of the public by maintaining adequate codes of safe and effective conduct. The professional regulatory agencies ensure that the health and social care services maintain the systems, culture and leadership standards to maintain sustained improvement in quality of care. This will allow health and social care service providers to maintain the standards of care in a cost and time-effective manner. The National Institute for Clinical Excellence, focuses on the needs of the National Health Services. Other quality measures of health care service include the Commission for Health Improvement that monitors and scrutinizes the service quality of a particular health care system (Ney et al., 2017). Evidence shows that most of the failures in healthcare service are due to system failure rather than an individual clinical error. Safe and effective quality of service is the accountability measure of clinical governance. A health care provider has the professional responsibility to make sure that their practice is safe and the incidents of adverse events are as less as possible. In addition, it is the responsibility of healthcare providers to make sure that the adverse events are documented so that future errors are avoided. Thus, professional regulatory agencies ensure that health and social care workers are capable of working in a competent manner in compliance with the national regulatory guidelines. Senior clinical and social practitioners are accountable for training their subordinates according to the expected standards of GMC (Thompson et al., 2017). It is critical for the junior health and social care workers to be held accountable for their actions at work and maintain an accurate record of their communication with clients that comply with the quality standards. In addition, organisations are liable to comply with professional regulatory guidelines, in maintaining the quality standards of

documentation, training and treatment. For this purpose, it is essential that healthcare and social care workers maintain a precise and immaculate record of their patient interaction in a safe and secure environment, where it cannot be forged. It is essential to revamp the current culture and practice in the health and social care sector. Most importance should be given to accurate record keeping and being accountable for one's interactions and behaviours at the workplace.

Importance of Accurate Record Keeping

The Good Medical Practice recommends the accurate documentation of healthcare records. The records should include the clinical presentation, diagnostic measures adopted in clinical decision making and the management plan agreed upon at the end of clinical evaluation. Accurate documents should also include the information provided to the patient regarding their care plan, medications or diagnostic interventions. According to GMC guidelines, the health care practitioner should record the details at the time of patient-doctor interaction so false details are not documented. The healthcare practitioner should also document the details of the consent, history, investigations, examination and clinical observations according to GMC guidelines. The estimated risk and benefit of each treatment option should also be documented in the treatment plan (O'Grady et al., 2018). In addition, the details of referral and follow-up should also be included in the clinical documentation.

Any advice given by the doctor regarding safety measures or seeking urgent care on flaring up of particular symptoms or signs, should also be documented. The contents of the clinical record need to be as precise and accurate as possible. This is also applicable for telephonic interactions of healthcare providers with the patient. It is highly essential to maintain accurate records to avoid unnecessary hassles during scrutiny and clinical governance evaluation. It is impossible for the health or social care practitioner to memorize the details of every patient interaction (Tian et al., 2019). However, during ethical and legal surveillance, those records become critical to their defence. The communication between health care provider and patient needs to be documented accurately by the nurse practitioner. In addition, when the patient journey is accurately documented, health care practitioners can reflect on them later on during clinical evaluations. It has become compulsory for healthcare practitioners to abide by the code of conduct and maintain accurate clinical records during their practice (Tian et al., 2019). These records include patient-doctor interaction as well as all other documents relevant to the practice of a health care

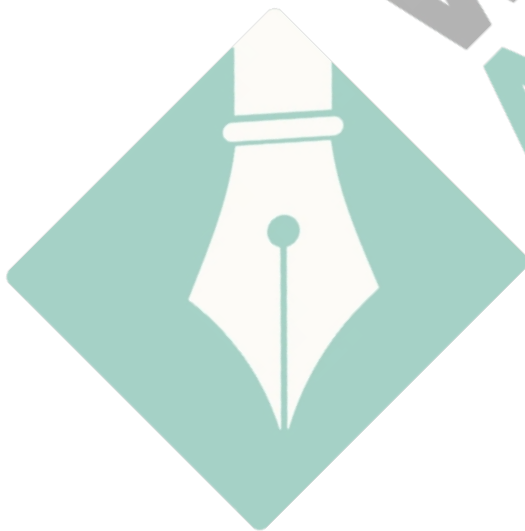
practitioner. Health and social care practitioners need to comply with protocols and make sure that they follow the standardized procedure for accurate record keeping (Zimmerman et al., 2019). All essential information should be noted and included in the pro forma document. The documents are a template and should not be copied without thinking. It is the duty of the healthcare practitioner to make sure that the accurate pro forma is being utilized for the clinical case under consideration. In addition, the transition from written to electronic records is quite challenging for the practitioner.

For this purpose, the healthcare practitioner needs to ensure they are trained in computer skills by the organisation they serve. In addition, many challenges are faced by the healthcare staff in acquiring access to the electronic documentation systems. Social care homes need to comply with the Care Quality Commission (CQC). According to CQC guidelines, social care homes need to provide safe, effective and responsible leadership to people (Thompson et al., 2017). Maintaining accurate healthcare records can create a positive impression on following CQC standards. In addition, maintaining accurate records shows that healthcare and social care practitioners are organized and responsible (Tian et al., 2019). The records are proof of the quality of care delivered in social and healthcare practice. In addition, it shows vigilance and monitoring of healthcare staff while delivering care to patients. It is an addition for organisations to allow easy access to documentation in order to follow CQC compliance. Along with this, maintenance of accurate records allows staff and residents to be aware of the treatment being given to every patient. This will avoid any miscommunication, delays and wrong treatment. Maintenance of accurate records will also allow staff to monitor the outcomes of treatment (Zimmerman, D.H., 2019).

Conclusion

In conclusion, accountability practices allow for adequate monitoring of healthcare and social care practitioners. The accurate documentation of care records will allow health and social care organisations in redesigning management protocols that lower the incidence of adverse events. The content of the healthcare document could be used in conducting research on the adverse events in the NHS. Being accountable for one's performance is essential in the development of appraisals for health and social care workers. In this way, the maintenance of accurate clinical documents will enable health and social care workers to be recognized and appreciated by the NHS. Being held accountable for their professional conduct, will enable health and social care workers to

identify pain points in their practise and address them. Accountability measures allow professionals to participate in personal and professional advancement programs. In order to abide by GMC guidelines, health care workers are required to maintain clinical records in folders to give proof for their claim to good medical practice. This will help health care practitioners in acquiring a license according to GMC guidelines every five years. Proper training needs to be conducted to make health and social care practitioners aware of the Good Medical Practice guidelines. This will support them in facing potential ethical or legal issues in the future in relation to their practice. Professional accountability will improve the quality of care and service in the health care sector.



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