

# The Informed Practice Nurse

Second Edition

Edited by Marilyn Edwards



John Wiley & Sons, Ltd



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This book is printed on acid-free paper responsibly manufactured from sustainable forestry in which at least two trees are planted for each one used for paper production.

This book is dedicated to my husband Chris who has encouraged and supported me in developing from a novice Practice Nurse to an Advanced Nurse Practitioner.





# Contents

Contributors	xi
Preface	xiii
Introduction	xv
<b>Chapter 1 Ethics</b>	<b>1</b>
<i>Pat Tweed, Cath Molineux and Marilyn Edwards</i>	
Ethics, philosophies and codes of practice	2
Issues of consent	10
Respect for patient autonomy in general practice	18
Summary	24
<b>Chapter 2 Management</b>	<b>31</b>
<i>Pat Tweed, Marilyn Edwards and Karen Mayne</i>	
Organisations	31
Change management	37
Clinical governance in general practice	40
Time management	48
Summary	56
<b>Chapter 3 Infection Control</b>	<b>61</b>
<i>Mandy Beaumont and Chris Baldwin</i>	
Introduction	62
Pathology of infection	62
Standard precautions	64
Minor surgery within general practice	69
Waste	73
Protection of staff and patients	73
Control of substances hazardous to health (COSHH)	76
Vaccine storage	78
Healthcare associated infections	79

	Infestations	84
	Notifiable diseases	89
	Summary	90
	Appendix	92
Chapter 4	<b>Health Promotion</b>	97
	<i>Diana Forster, Diane Pannell and Marilyn Edwards</i>	
	Needs assessment	97
	Social class and health needs	103
	Practice and community profiles	105
	Promoting pre-conception care	107
	Infections	113
	Genetic disorders	116
	Women with diabetes mellitus	117
	Prevention and management of osteoporosis	117
	Summary	128
Chapter 5	<b>Men's Health</b>	135
	<i>Marilyn Edwards and Glenn Turp</i>	
	Social issues surrounding men's health	135
	Healthcare services	139
	Well men	140
	Improving men's health	143
	Testicular cancer	144
	Prostate cancer	148
	Men who have sex with men	154
	Summary	161
Chapter 6	<b>Women's Health</b>	169
	<i>Georgina Paget, Gudrun Limbrick and Marilyn Edwards</i>	
	The invisible minority; health needs of lesbian women	169
	Premenstrual syndrome	178
	Domestic violence (domestic abuse)	190
	Summary	199
Chapter 7	<b>Health Needs of Young People</b>	205
	<i>Sue Jones, Marilyn Edwards and Wendy Okoye</i>	
	Nutritional issues in young people	205
	Eating disorders	215
	Teenage health care	224
	Summary	233

Chapter 8	<b>Wound Management in General Practice</b>	239
	<i>Joy Rudge</i>	
	Types of wound	239
	The healing process	240
	Wound assessment	245
	General assessment of the patient – factors affecting healing	251
	Wound cleansing	254
	The ideal dressing	255
	Dressing types	258
	Management of minor traumatic wounds	263
	Management of post-operative wounds	265
	Management of leg ulcers	265
	Nursing management	271
	Summary	275
Chapter 9	<b>Moving Practice Nursing Forward</b>	279
	<i>Marilyn Edwards</i>	
	Nursing in practice	279
	Nurse-led management in clinical care	280
	Skill mix	280
	Non-medical prescribing (nurse prescribing)	289
	Triage	293
	The primary healthcare team	294
	Training	294
	Reflective practice	296
	Clinical supervision	297
	Practice based commissioning	298
	Nurse partnerships	298
	The future	299
	Summary	301
Index		307



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# Preface

The second edition of *The Informed Practice Nurse* has been written in response to the dynamic nature of general practice nursing. Updates from the first edition include reference to Nursing and Midwifery Council and deleting drugs, treatments or managements that are no longer available or recommended. All chapters have been updated with references to reflect topical issues relating to each subject. New material has focused on change management, which recognises the valuable input of practice nurses in their organisations, domestic abuse that affects all strata of society, issues relating to diet and childhood obesity, advances in wound management and the changing role of the practice nurse.

Nurses have to be informed in order to deliver sensitive and holistic care. I hope that each reader will learn at least one new fact that will improve their knowledge and understanding, reflect on it and use it to improve patient care or safety.





# Introduction

This book has been planned to meet the needs of practice nurses, and includes many issues that relate to other community nurses and medical colleagues. Examples of real or hypothesised practice, with recommendations for implementing quality care, relate specifically to general practice. The reader can probably refer to other examples to fit particular fields. Most of the chapters are subdivided into specific subject areas. For example, the chapter on Women's Health is subdivided to include the health needs of lesbian women, premenstrual syndrome and domestic violence (domestic abuse). This structuring allows ease of access to these topics.

Nursing ethics underpins all patient care and nursing action, and is essential to protect both nurse and patients (Chapter 1). Personal and professional accountability and patient autonomy, which are integral to all aspects of patient care, are stressed throughout the book and should stay in the forefront of the reader's mind. Most of the chapters interrelate, with topics such as ethics, management and health promotion being essential components of all basic consultations in general practice.

Although the book is not a clinical handbook, wound management (Chapter 8) is included to demonstrate how the introductory chapters relate to patient care. These issues can be transferred to other areas of practice. For example, risk management, informed consent, time management, infection control and health promotion (Chapters 1–4) should be considered for all routine procedures, including child vaccinations and cervical cytology. Health profiling and needs assessment (Chapter 4) is essential when planning a strategy for commissioning and delivering services for men, women and children (Chapters 5–7). Issues relating to domestic abuse relate to all ages and genders.

The practice nurse role continues to develop and expand, with increasing autonomy, skill mix and opportunities for nurse-led clinics. The benefits and drawbacks to these roles are discussed in Chapter 9.

Evidence-based information is crucial to support nursing practice and will be found throughout the text. Inevitably there is some overlap between

chapters because topics cannot be compartmentalised. This overlap will reinforce relevant issues. The content of the chapters are explained through a brief précis of the rationale for, and content of, the text. Recommended reading and resource lists, found at the end of each chapter, will assist the reader to access more detailed information on topics that interest them.

It is hoped that issues raised in this book will encourage nurses at all levels to question both own their practice, and that of their medical and nursing colleagues where necessary, and to use evidence-based knowledge to negotiate appropriate care for their patients.

Quality nursing is independent of the political climate with its constant change of health policy; any mention of specific health policy is purely accidental.

# Chapter 1

## Ethics

*Pat Tweed, Cath Molineux and Marilyn Edwards*

'Ethics' is derived from the Greek word *ethos*, meaning spirit of a community; this is the collective belief and value system of any moral community, social or professional group (Reeves & Orford 2002). Morals and values are inter-related and integral to society. The study of ethics helps one to consider what kind of things are good or bad and how to decide whether actions are right or wrong. Ethics and the law are closely interwoven, as our laws are usually based on ethics (Holland 2004).

The role of codes of practice in ethical decision making is discussed in this chapter using examples from general practice. The reader will recognise many of the examples cited in the chapter, and will probably be able to describe many more.

In order to assess the effectiveness of codes of practice in making ethical decisions in nursing, one must first consider what is meant by an ethical decision. This chapter examines the codes of practice for nurses, following a brief description of ethical principles. *The Code of Professional Conduct* (Nursing and Midwifery Council 2004) will be referred to as 'the Code', the principles of which may conflict with issues relating to power and authority in the primary healthcare setting. The Code has been reviewed and modernised, and is expected to be rolled out in January 2008 (Nursing and Midwifery Council 2007), but the main principles are unlikely to change.

Doctors and nurses may sometimes forget the rights of patients in the rush to 'get the job done', meet targets and appear efficient. This is an area that nurses can readily address and possibly share with their primary healthcare team colleagues. Informed consent, for both adults and minors, is essential if the patient is to be involved in their care and be autonomous. Patients with a learning disability pose a greater challenge in obtaining informed consent. The issues discussed within this chapter are pertinent to all areas of nursing care, and are referred to throughout the book. There is inevitably some overlap between sections, but this serves to emphasise the importance of certain issues.

The reader is directed to Beauchamp and Childress (2001) for an in-depth discussion on ethical theory.

*The Informed Practice Nurse*, Edwards, M. (2008), Chichester: Wiley.

For convenience the term 'patient' will be used in the text, although it is recognised that many people who consult the nurses are 'well people'.

## **Ethics, philosophies and codes of practice**

### *Ethical philosophies and theories*

The two main philosophies of ethical reasoning, utilitarianism and deontology, have almost diametrically opposed prime principles (Seedhouse 1998). John Stuart Mill and Jeremy Bentham propounded utilitarianism, believing that the ends justify the means and that the right action is the one that offers the greatest good to the greatest number.

Deontology (derived from the Greek word *deon*, meaning 'duty') is the theory associated with Immanuel Kant. It is based on duty and respect for the individual, who must be treated as an end in themselves and never as a means to an end. It is the action itself that is right or wrong; the consequences are less important.

When faced with a moral dilemma where there are two alternative choices, neither of which seems a satisfactory solution to the problem, a decision has to be made based on one's own moral principles and what each person believes to be right. The rules that guide thinking are known as ethical principles. The four principles of biomedical ethics listed below are discussed in depth by Beauchamp and Childress (2001).

Autonomy relates to respecting and preserving people's ability to decide for themselves.

Beneficence is the obligation to provide benefits and balance benefit against risk.

Non-maleficence refers to the obligation to avoid doing harm.

Justice is fairness in the distribution of benefits and risks.

In his text on ethical theory and practice, Thiroux (1980) outlines five ethical principles that he considers to be applicable to all spheres of life, adding honesty to the main four principles (Box 1.1).

#### **Box 1.1 Ethical principles, applicable to all spheres of life (Thiroux 1980)**

- The value of life and respect for persons
- Goodness or rightness
- Justice or fairness
- Truth telling or honesty
- Individual freedom or autonomy

### *The functions of codes of practice*

The three functions of professional codes identified by Burnard and Chapman (1988) are ethical, political and disciplinary. This section will concentrate mainly on the first of these, although the impact of the other two will be clearly shown. Codes of practice are recommended by professional organisations, as many types of human conduct are harmful, although not illegal (Seedhouse 1998).

Codes of practice are meant to inform and reassure members of the public about the quality of the professional service, as well as enhancing the public image of the individual practitioner. The purpose of the code is to inform the profession of the standard of professional conduct required of them in the exercise of their professional accountability and practice (Nursing and Midwifery Council 2004). It can be used to fight for improvements in standards, although this is not always an easy path to take, as will be seen later.

Professional codes also play a part in supporting the status of a profession. A code of conduct has been said to be one of the defining characteristics of a profession (Jaggard, quoted in Chadwick & Tadd 1992). The implication is that those within the group can be trusted to regulate their members and, if necessary, to discipline them if they fail to uphold the high standards of the code.

However, the Nursing and Midwifery Council (NMC) Code of Professional Conduct is issued for guidance and advice, laying a moral responsibility rather than a statutory duty on members of the profession (Young 1989). The Code can be used by a nurse to measure her own conduct, in the knowledge that the requirements of the Code are used by the NMC during trials of misconduct. Failure to comply with the Code may result in a nurse losing her registration. The Code of Professional Conduct is therefore a guide, a political statement and a means of regulating the profession.

### *The emphasis of the Code*

The NMC Code sets out the professional accountability of each registered nurse, midwife and health visitor working in clinical and management settings. Although the Code may have considerable influence over a nurse's resolution of ethical dilemmas, each situation for each person is unique, and is only a guide to decision making. A code may stress the most important considerations that should influence a decision, but a nurse cannot turn to the Code and expect it to provide a moral answer to an ethical problem. Nurses do not leave their moral choices behind when they are at work (Chadwick & Tadd 1992).



**Figure 1.1** Preconditions to accountability (from Bergman 1981).

The Code commits each individual nurse, midwife and health visitor to safeguard and promote the interests of both society and individual patients. It also requires that each shall act in such a way that justifies the trust and confidence of the public, and uphold and enhance the good reputation of the professions. In order for the nurse to fulfil these requirements, emphasis is placed on four main areas: knowledge, skill, responsibility and accountability; these were the basis of the principles of the Scope of Professional Practice (United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) 1992).

Bergman (1981) listed four preconditions to accountability, which were almost the same as the areas defined by the Code, but also included the need for authority (Figure 1.1).

### ***Knowledge and skill***

The Code places on the practitioner the continuing responsibility to maintain and develop their knowledge, skill and competence, through self-assessment and the production of a personal portfolio. Clause 6 clearly states that each nurse must acknowledge personal limits of knowledge and skill and take steps to remedy any relevant deficits in order to meet the needs of patients; a reflection of Thiroux's principle of honesty.

The Code does not say what each nurse must learn, but acts as a guide. A nurse, faced with the dilemma of being asked or instructed to carry out a

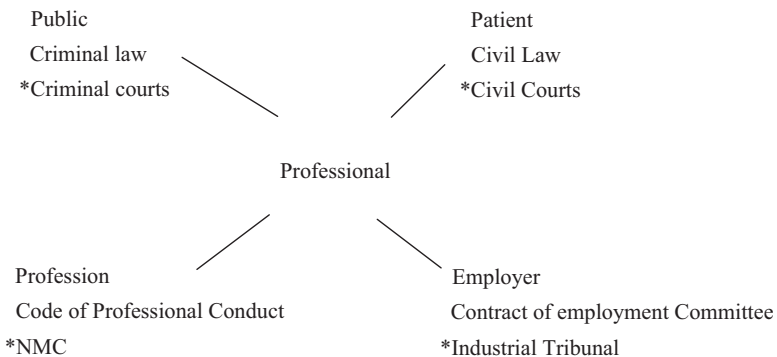
procedure that they do not feel fully competent to do has the support of clear principles on which to act.

The perception of competence can differ between a nurse and the employer (Jones 1996, p.83). This is a common situation in general practice, where the old medical adage of 'see one, do one, teach one' is often quoted. The ethical principles involved here are non-maleficence, the primacy of the patients' interest (respect for persons) and the justification of public trust. Castledine (1992) stressed that an individual nurse should feel safe and secure in their own performance before undertaking any task.

### *Responsibility and accountability*

Responsibility and accountability are closely linked, but not synonymous. Accountability is the acceptance of that responsibility, the willingness to explain one's actions and to receive credit or blame for the results of those actions (Evans 1993). One can be responsible but not accountable, though one cannot be accountable without being responsible (Young 1989). A registered nurse, midwife or health visitor is accountable to the patient, the profession, the law and the employer. This is shown in Figure 1.2, which indicates the groups to whom the registered nurse is accountable, the basis of that accountability and the authority empowered to judge the actions of the nurse in each area.

Practice nurses are developing their role in primary healthcare, often by taking over work that was previously seen as the province of the doctor. This role should develop in response to patient need and through experience gained by post-basic education. In general practice, this development has



**Figure 1.2** Areas of professional accountability.

\*represents the authority empowered to judge the actions of the nurse in each area.

resulted in nurses taking the lead in the management of chronic conditions such as asthma, diabetes and coronary heart disease. The role requires both medical knowledge and nursing skills of education, health promotion and counselling. Patients should be included in all the stages of decision making in their care, thus protecting patient autonomy (Clause 2 of the Code). However, it is all too easy to take on the medical model of treatment and cure, accepting delegation of a task, such as the application of cryocautery, from a doctor (Jones 1996, p 125). Nursing skills can be soon forgotten in the excitement and interest of new technology. Nurses who develop assessment and prescribing skills will be aware of their competencies and accountability.

The degree of accountability within a particular situation must surely be linked to the measure of authority held by the individual, as without that authority, one is not free to make an ethical decision regarding a problem (Tadd 1994). The Code does not mention this concept in relation to accountability, but insists that all practitioners are equally accountable.

### *Issues of power and authority*

In a work situation, conflict may arise between the humanist values of the Code and the authoritarian values of the organisation. Safeguarding and promoting the interests of patients and patients may or may not mean following instructions (Tschudin 1994a).

Challenging action could be considered as advocacy on behalf of a patient. An advocate is one who pleads on behalf of another, influencing those who have power for those without (Reeves & Orford 2002). This is a positive, constructive activity recommended as a role for nursing by the UKCC (1989), particularly where a person is incapable of giving informed consent. The Code, Clause 2.4, includes helping individuals access health and social care, information and support relevant to their needs. The issue of informed consent will be addressed later in this chapter.

### *The nurse–doctor relationship*

Traditionally the doctors made all decisions regarding the care of the patients, and imposed their authority over the work or decisions of other members of the team; work in which they had no particular training or skill. Modern practice has fortunately changed this relationship to one of complementary respect for roles. Chadwick and Tadd (1992) argue that where issues are of an ethical nature, the doctor has no particular expertise and should not hold power. The nurse has a responsibility to point out poor practice, to explain current thinking and, if necessary, refuse to take part in a procedure;



refusing, for example, to assist in minor surgery with unsterile instruments (see Chapter 3), or to apply a dressing that could prejudice wound healing and may cause harm (see Chapter 8).

The doctor's authority in medical matters is only legitimate if they perform correctly. The nurse must intervene if they know or suspect it to be wrong (Chadwick & Tadd 1992). In acting to safeguard the well-being of a patient (Clause 1), the nurse must be aware that although this may mean acting as the patient's advocate, they must not place themselves outside other sections of the law by refusing to co-operate with treatment that the doctor has prescribed (Young 1989, p 206).

If the problem were of a serious nature the nurse may feel it necessary, in order to protect the patient (Clause 8), to report the matter to a higher authority. This may be an informal discussion with the head of the clinical governance committee at the Primary Care Trust, if the nurse does not have a nurse manager. The probable harm, in the form of damage to team relationships, or public mistrust, should it become more widely known, must be weighed against the benefit to patient care. This has been demonstrated by the ability of Harold Shipman to cover his malpractice for so long. No one likes to make a fuss, but nurses have a responsibility to share their concerns.

### *Truth and trust*

Trust has to be earned; it places obligations on the individual nurse, not the least of which is honesty. Clause 3.1 includes the need for information to be accurate and truthful, although Reeves and Orford (2002) raise the issue of being economical with the truth, or telling white lies. Failure to be honest with a patient and answer questions relating, for example, to an incurable disease, because of a moral decision made by medical staff and/or relatives, conflicts with obligations relating to competency, consent and right to information. This is likely to destroy the relationship of trust and confidence. The responsibility to provide information rests with the practitioner and 'if something less than the whole truth is told, it should never be because the practitioner is unable to cope with the effects of telling the truth' (UKCC 1989).

### *Abuse of the individual practitioner*

Nurses have always accepted the need to do their best under difficult circumstances, even to the extent of pretending they can cope, when they clearly cannot (Pyne 1994). Clause 8.4 states that the nurse's first consideration in all activities must be the interests and safety of the patient. Nursing management has a responsibility to draw attention to inadequacy of resources

when an unacceptable workload is placed on individual practitioners (Clause 8.3).

Pyne (1992) urged nurses to support each other in the interests of the patient, but many practice nurses still work alone, so that the need for a system of peer support, with a route to senior nurses within the health authority is vital. Practice nurse forums and clinical supervision are two means of offering and sharing support (see Chapter 9). They can provide guidance to help address a problem, as peers may have dealt with similar scenarios.

The ethical principle of respect for persons applies to colleagues as well as to patients (Tschudin 1994b). Despite Clause 8.3, nurses will still feel vulnerable if they complain about colleagues, although less so if complaining about working conditions or equipment.

### *Confidentiality*

Confidentiality, in the clinical setting, implies respect for information about a patient that has been given in trust. This information will not be passed to other people without the consent of the patient, except where disclosure is required by law, or by the order of a court, or is necessary in the public interest (Clause 5). Breaches of confidentiality should be regarded as exceptional. Clause 5.1 states that the nurse should ensure that patients understand that some information may be made available to other members of the team involved in the delivery of care. Patient-held records involve the patient sharing in, and having ownership of, his own record. Diabetes, rheumatoid arthritis and ante-natal are examples of conditions where records may be shared by a variety of professionals, but the patient must be a partner in this, controlling the flow of information and not just transporting the card.

On occasions a patient may share personal information that they do not want recorded or passed to a third person. They have a right to expect that their wishes will be complied with, for if they cannot rely on respect for confidences, they will be unlikely to seek help when they desperately need it. However, this can pose a dilemma for a nurse. Omitting relevant data from a patient's records may later be detrimental to future patient care, for example issues relating to sexual health or drug abuse.

There are, however, instances when acting in the interest of the patient may conflict with the interest of society; for example, when the information concerns the welfare of a third person who may be at risk, such as a child in a family where there is violence against another person. Clause 5.4 applies where there is an issue of child protection.

The General Medical Council requires that the practitioner should discuss the matter fully with other practitioners and if appropriate consult with a

professional organisation without identifying the person concerned (Korgankar & Tribe 1994). If a decision is made not to disclose or provide the information in the record, it must be recorded elsewhere along with the reasons for such action and kept for future reference (UKCC 1987). However, when the patient is alcoholic, or has diabetic retinopathy, and continues to drive, the nurse has a responsibility to report this to the employer, who may then report this to the DVLC.

The question of which members of the primary healthcare team need to have access to information about a specific patient is included in Clause 5.1. It is accepted that it is impractical to gain consent every time information is shared within the team. Patients and carers must be made aware of the need for information to be shared, on occasion, with other health professionals and who those people are likely to be. In a large team there is a greater need for awareness of these issues.

The UKCC document, *Confidentiality* (1987), warned of the danger of careless talk. Sadly this basic human failing is not mentioned in later documents. Discussion of a patient's problems with a colleague in a public place, such as in an office which is open to a waiting area, or on a phone in reception, can cause confidential information to be released into the public domain and bring about complete loss of faith in the service. Even in areas that are reserved for staff, confidential details can be passed around over coffee so that information that a patient shared in confidence with one professional becomes public property.

Although many practices are paper-less, and rarely refer to the old record cards, it is essential to maintain confidentiality of data on the computer screen. This applies equally when partners attend together but do not wish their medical history to be shared, or young people attend with parents but wish to keep a previous consultation confidential.

### Activity 1.1

Consider how your workplace, reception, treatment rooms, computer screens and telephones used by staff threaten confidentiality of patient information. What changes could be made to protect confidentiality?

### *Advertising and sponsorship*

The Code warns against endorsing commercial products (Clause 7.3). A nurse may wish to recommend a blood glucose meter that she believes to be reliable in monitoring diabetes or give out health promotion leaflets or information sponsored by a drug company. This could be considered

manipulation by a commercial concern or may give the impression that the profession as a body recommends a product, when other nurses might disagree (Chadwick & Tadd 1992).

It would be wise to discuss several makes of glucose meter, pointing out their advantages, disadvantages and any independent evaluation, then allow the patient to make their own choice. However, this presents problems when only specified glucose monitoring strips are prescribed from a practice formulary.

Nurses deal with people who are vulnerable and open to suggestion. It is incumbent on nurses to see that literature offered has first been read, to ensure that the message is balanced and unbiased and does not directly promote a product or a company. Also ensure the data is still relevant; old information leaflets may be incorrect. For example, leaflets discussing the benefits of hormone replacement therapy may not have been updated in line with current evidence and practice. It has to be recognised that many practices rely on support from pharmaceutical companies for health promotion literature.

Drug company sponsorship for study days and research projects is especially common to general practice. It is reasonable to assume that the valuable support of a company can lead to the advocacy of a particular product because of greater familiarity.

### **Activity 1.2**

Consider the areas of patient care where you influence the choice of treatment. Do the drug companies who make the products you choose most frequently also provide sponsored educational events for nurses? Can you give examples of judgement swayed by commercial propaganda?

## **Issues of consent**

The legal system in the United Kingdom requires consent from any patient who is about to undergo any treatment or surgical intervention. Without consent from the patient, the nurse or doctor delivering the care may be in danger of being sued for assault and battery. The following text relates to adults, minors and persons with a learning disability.

### ***What is consent?***

Consent to any medical or surgical intervention is a legal arrangement based on the notion of a contract between two equal parties (Alderson 1995). There

is some debate as to whether equality exists between these two parties. The health professional would appear to have the upper hand by having greater knowledge of the procedure being undertaken. This may create barriers between the health professional and patient in such a way that: the patient feels coerced into something against his will; and some doctors claim it is unfair to burden patients with technicalities they would not understand.

Some patients prefer to be kept in the dark and accept a suggested treatment; others will require information about all the choices on offer, and then make a decision; while a third group will want all the information and then trust the health professional to make the right decision for them (Reeves & Orford 2002).

Although some patients may wish to take the submissive role and allow decisions to be made for them, this decision making is not the role of the health professional. Information regarding the procedure must be imparted to the patient who is then enabled to make their own decision – informed consent. This issue will be discussed later.

### *Express and implied consent*

Consent can be given in three ways; expressly, implied or hypothetically (Reeves & Orford 2002). Express consent is usually in the form of writing, an example of which is the pre-operative consent form, but includes a nod of the head, or a verbal yes. Parents or guardians who attend with a child for vaccination would normally expect to sign a consent form.

Nurses working within general practice will usually encounter implied consent. It would be assumed that a patient who voluntarily attends a flu clinic and proffers an arm for vaccination has given implied consent to the procedure. However, women may be sent to the nurse by the doctor for vaginal swabs, but do not understand the implication of a positive chlamydia result. Hypothetical consent will rarely be encountered by the nurse, but includes an advance directive, or living will, which is discussed later in the text.

Although, legally, verbal consent is as valid as written consent, written consent is easier to produce in cases of litigation (Leung 2002), and can be scanned into patient computerised notes.

Many general practices offer training facilities, so a patient may find a student nurse, family planning student, medical student or GP registrar present during the consultation. Written consent should be obtained prior to the consultation, to give patients the opportunity to decline the observer if they so wish before they are confronted with the learner. This is particularly relevant for intimate consultations such as cervical cytology, when the woman may prefer not to have either a male or female learner in attendance.

Even if there is no objection it is important that the patient is allowed to control the flow of information. The requirements of the student must not take precedence over the need to seek consent.

### ***Consent in English law***

It is a basic rule of English law that no one has any right to touch another person without their consent. A nurse may not, therefore, do anything to a patient without obtaining their agreement. The importance of this law is to ensure that patients understand and agree to the treatment suggested. Consent must not be coerced and the benefit of any intervention must outweigh any harmful effects (Bird & White 1995).

Exceptions to this law involve some aspects of nursing care. This exception also permits the nurse to care for unconscious patients, which may be a simple faint or the need for cardio-pulmonary resuscitation in primary care.

### ***Competence to consent***

A person must be of adult years and sound mind to be capable of giving consent (Rodgers 2000). Informed consent for medical or surgical procedures may be hindered by illness, stress, mental illness or a learning disability (Chadwick & Tadd 1992). A person who is mentally incapable of understanding the nature of the treatment cannot consent to treatment. Mental competence must be assessed before obtaining valid consent. The Mental Health Act Code of Practice 1983 para. 15.10 stated that certain criteria are necessary for a person to be able to consent to treatment (Box 1.2).

If a patient is unable to give consent due to a psychological disorder, illness or stress, the relatives usually have to shoulder the burden, although the final decision will lie with the doctor. A diagnosis of mental illness does not

**Box 1.2 The criteria necessary for a person to be able to consent (Mental Health Act 1993 para 15.10)**

The patient:

1. understands what the treatment is and why he/she needs it
2. understands in broad terms the nature of the treatment
3. understands the benefits and risks
4. understands the consequences of not having the treatment
5. possesses the mental capacity to make a choice.

necessarily mean that the ability to give valid consent is affected. Fullbrook (1994) argued that the question of a patient's competence to consent to treatment is rarely raised unless there is an issue of non-compliance. He also states that the capacity to make a decision is judged in relation to the importance of the intervention. This scenario can be related to general practice. A patient who, after consultation with his general practitioner, decides against a minor surgical procedure, would have his decision respected. If this same person refuses major surgery, his mental competence could be questioned. The reader may have cared for women with advanced breast cancer who choose not to have surgery, and found it difficult to accept this decision.

Competence to consent can therefore be linked to a question of conforming. An individual has a right to make their decisions, but mental competence may be questioned if the final decision fails to conform to society's expectations. Standards may be the norm for either an individual or society. Usually when such a conflict arises the final decision is made by the person with the most authority and knowledge.

### *Consent for patients with learning difficulties*

Mentally compromised patients are said to be unable to, or not allowed to, exercise their autonomy to its fullest extent because the ability to make autonomous decisions must be competency based (Fullbrook 1994). However, mental competence is not easily measured and may require expert analysis. This is a complex process, and in clinical practice the assessment of mental competence tends to be value judgements based on social and personal values (Hepworth 1989).

Consent for patients with severe learning difficulties, or the senile, who are regarded as incompetent to give valid consent, is usually sought from a third party. Relatives, carers or friends may be able to give an indication of the patient's wishes (Reeves & Orford 2002). Although relatives are often asked to make surrogate decisions on behalf of the patients, Fullbrook (1994) suggests that they may be mentally incompetent themselves, due to stress that may affect rational judgement.

Hanford (1993) raises ethical issues surrounding disability. She states that 'disability is rarely, if ever, given consideration in ethics teaching, even though autonomy is central to the concerns of the disabled'. This can relate to physical or mental disability. Hanford raises concerns about the moral stance professionals assume in ethical deliberations, which is central to any discussion on ethics and disability.

Nurses who care for patients with a learning disability may well have encountered the challenge of competence and consent. The three main areas of concern include immunisation, contraception and cervical cytology. These

are invasive procedures that may be difficult to explain in a language the patient understands. Many of the patients who live in the community will have a key worker who has a deeper understanding of their patient's mental ability. It may be necessary to defer a procedure until the key worker can obtain the necessary consent.

A person is more likely to give valid consent if the explanation is appropriate to the level of their assessed ability (Rumbold 1993). Nurses can utilise the expertise of their learning disability nurse colleagues to ensure that patients with limited mental competence receive quality care. These nurses have the skills and tools to help the patient understand a procedure. Clause 3.6 in the Code states that criteria for treatment must be in the patient's best interests when they are not legally competent.

### *Informed consent*

The concept of informed consent has existed for many years within the medical profession. Cadoza in 1914 stated that 'Every human being of adult years and sound mind has a right to determine what shall be done with his body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable for damages' (cited in Rumbold 1993).

Informed consent has been defined as the patient's right to know what is entailed, before any procedure is carried out (Chadwick & Tadd 1992). This includes an explanation of any hazards or complications, and the expected final outcome of treatment. Beauchamp and Childress (2001) discuss the complexities of different commentaries about informed consent.

Simply, within general practice, it is the nurse's responsibility to ensure that the patient is fully informed about any procedure or treatment, even when they have given implied consent by attending the surgery. The patient will be competent to understand and decide voluntarily, having been given accurate information that they can understand and authorize the agreed plan of care.

The patient must be given all the relevant information in order for consent to be obtained. In England there is no actual law that stipulates how much information is given, but it is the health professional's duty to ensure that there is no undue pressure or influence on the patient. These issues emphasise the link between consent and autonomy in allowing individuals to be autonomous, and permitted to make their own decisions regarding their healthcare.

Beauchamp and Childress (2001) argue that informed consent does not exist genuinely between professional and patient, as the patient can never fully understand the information they are given. This reinforces the issue of an unequal contract between health professional and patient. As mentioned above,



stress and illness may influence the patient's ability to make a rational decision even if all the information has been provided. It may be appropriate in some instances to defer a treatment until informed consent can be obtained.

### *Main principles of informed consent*

Although some patients are unable to form an informed opinion, it must be remembered that everyone has the same rights and the two main principles must be (Rumbold 1993):

- Give people the respect due to any human being
- Ensure that the person is protected from harm

If a person is unable to give informed consent, it is considered good practice to discuss any proposed treatment with the next of kin (National Health Service Management Executive (NHSME) 1990), although the doctor does not have to obtain their consent as the final decision in law rests with the doctor. Failure to obtain consent or adhere to a competent refusal may result in legal action, or disciplinary proceedings against the practitioner (Rodgers 2000).

### *Cultural issues*

Regard must be given to the cultural backgrounds within the practice population when considering informed consent in both adults and children. Difficulties with language can clearly have an impact when obtaining consent for treatment (Box 1.3). An interpreter may be required for patients whose first language is not English. This may be a child or relative, which creates problems with sensitive issues and patient confidentiality, although without an interpreter, the patient is unable to give informed consent. Access to telephone or personal interpreters is difficult and expensive, and may not be commonly considered in primary care.

#### **Box 1.3 Examples where language barriers may prevent the nurse obtaining informed consent**

- Parents who do not speak or understand English are unable to give informed consent to a procedure for their child
- Administering of vaccines, including influenza
- Prescribing diabetic medication and insulin
- Undertaking any bodily examination, including cervical smears
- Travel advice, including choice of malaria prophylaxis.