

New rights for patients: Where do they fit in critical care?

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Overview

- Influences on consent in the relationship between patients and health professionals
 - patient-specific factors
 - common and statute laws
 - nature of health problem(s)
 - longevity/familiarity of relationship
- Recent changes in the laws
- Implications for day-to-day nursing practice in critical care

Critical care patients

- Broad range of mental capacity
 - Unconscious (iatrogenic or aetiological)
 - Fluctuating capacity (delirium or illness)
 - Fully capable
- Broad range in the source of patients
 - trauma & emergency care (including surgery)
 - acute deterioration of a medical condition
 - long-term conditions with periods of acute illness
 - elective surgery
- The approaches to consent are just as broad

Influences on consent

- Battery and assault are not used by the courts in relation to healthcare
- The usual test is *negligence*
 - Was the professional negligent in the way they took consent for the intervention?
- Valid consent has three aspects
 - A meaningful exchange of information
 - The patient remembers the information
 - The patient arrives at an uncoerced decision

Influences on consent

- In *principle* self-determination is the binding factor
- However in both health and legal practice, sanctity of life is given great importance
- *Best interests* must be preserved if the patient lacks mental capacity to consent
- Advance directives are valid but have strictly limited application

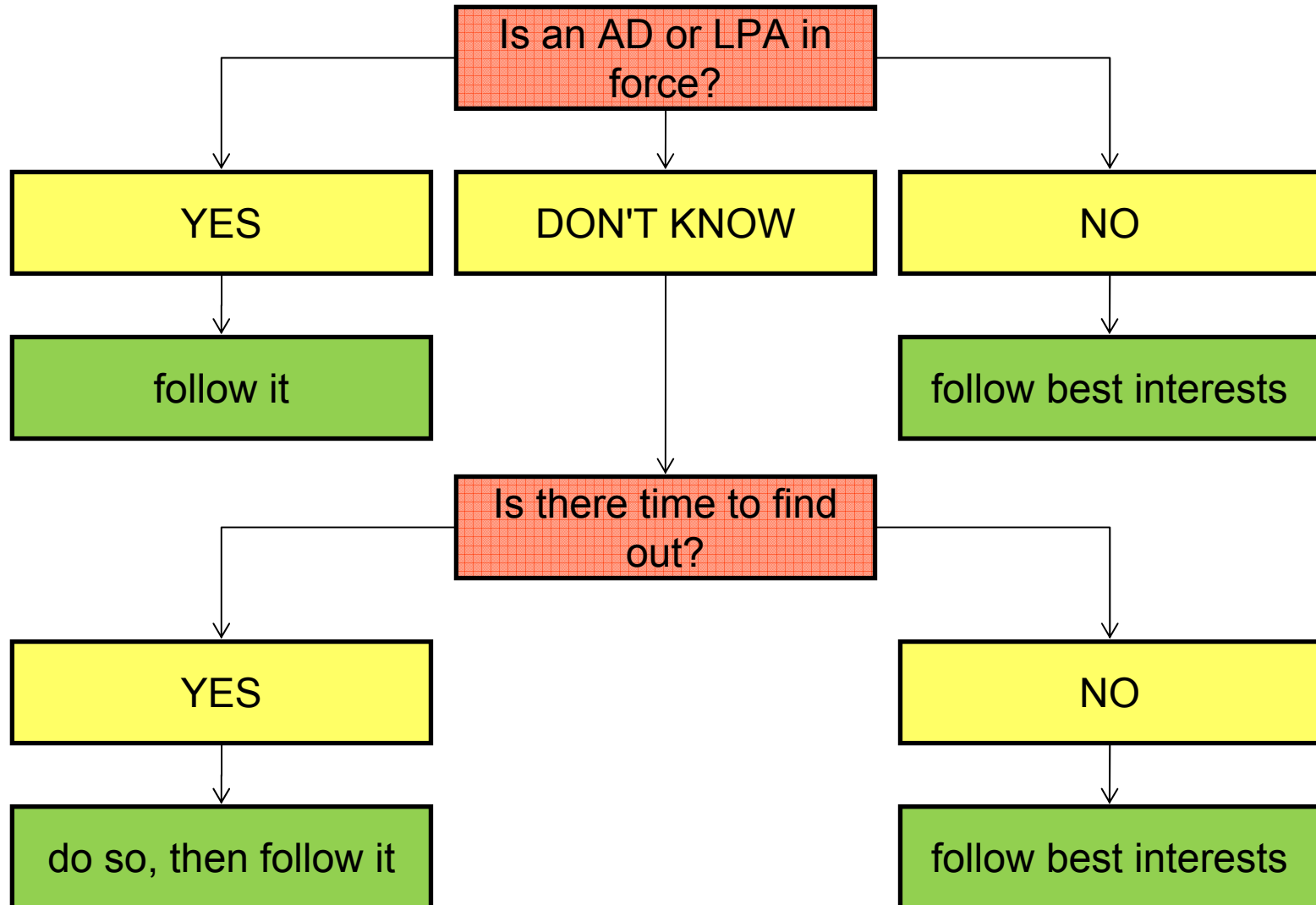
History of problems

- Common law regarding the standard of consent is unclear
 - (*Sidaway v Bethlam Royal Hospital* 1985)
- *Informed* consent has been rejected in favour of the *therapeutic privilege*
- The best interests principle has not been applied consistently and clearly by practitioners
- The Mental Capacity Act 2005 was a long time coming

Current and future influences

- The Mental Capacity Act 2005 has 5 key features
 - Presumption of capacity
 - Duty to support potential for capacity
 - Continued application of the *best interests* principle
 - Recognition of Advance Directives
 - Lasting Power of Attourney for health care decisions
- The act legislated the best of the common laws

Emergency algorithm (patient lacks capacity)



Elective patients

- Pre-admission assessment is medically led
 - Data collected is medically orientated
- Information gathered is often not communicated beyond anaesthetic departments
 - theatre and critical care nurses cannot pre-empt problems
- Nursing problems typically diagnosed on arrival:
 - alcohol/nicotine dependence
 - sleep apnoea
 - needle or mask phobia

Elective patients

- Care is planned responsively rather than preemptively
- Delays cause longer stay and greater risk
- Scope for critical care and perioperative nurses to request a data set from pre-admission clinics (Hurley & McAleavy 2005)

Why seek out advance directives?

- Nurses are required to advocate for patients (NMC 2008)
- Failure to consider advance directives and powers of attorney threatens patient autonomy
- Professionals have flexibility when deciding the validity and applicability of an advance directive
- There is the option to refer disagreement or doubt to the Court of Protection