Nurse practitioner-led consent in day case cataract surgery

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This article explores issues relating to non-medical personnel gaining informed patient consent for procedures in nurse-led clinics. It examines the results of two snapshot audits, which indicate that nurse-led consent may be effective in increasing the efficiency of clinics, while also bringing about benefits in terms of a more streamlined service for patients, and increased job satisfaction for nurses.

Over the past 10 years, a number of professional and legislative documents have provided the impetus for the expansion of nurse-led services. This began with the ‘New Deal’ for junior medical staff (NHSMI, 1991), which resulted in a reduction in junior doctors’ hours, and the subsequent re- allocation of some routine medical duties to nursing staff. This was facilitated by the UKCC document, The Scope of Professional Practice (UKCC, 1992), which allowed nurses to expand their roles within their own, and their organisations’ capabilities.

More recently, the Department of Health has published a number of papers that emphasise the expanded role of both nurses and nurse practitioners in increasing the efficiency and quality of service provision within the NHS. More notable among these are the documents Making a Difference (DoH, 1999), which highlights exemplar sites in which nurse-led services are streamlining health care delivery, and perhaps even more significantly The NHS Plan (DoH, 2000), in which the chief nursing officer lists her 10 key roles for nursing. One of these key roles is the ‘nurse-led clinic’, and more specifically the act of gaining informed consent for a proposed intervention within the clinic.

The setting

Since the end of 2000, the Day Surgery Unit at Prince Charles Hospital has provided nursing input into the preoperative assessment of day-case patients for cataract surgery. The service developed considerably over the ensuing three years, with the gradual withdrawal of direct medical input as the skills and confidence of nursing staff increased. This culminated in the employment, in April 2002, of two ophthalmic nurse practitioners, who now run a pre-admission clinic within set protocols. They refer to medical staff only in the event of complex pathology or co-morbidity.

However, prior to the introduction of the ‘health professional’ consent form, the nurse practitioners were unable to complete the whole of the preoperative assessment procedure. Patients would therefore have to undergo assessment with one of the ophthalmic nurse practitioners, and then either endure an often lengthy wait within the outpatient department in order to sign with the senior house officer, or sign the consent form on the day of surgery – a practice not recommended within the literature (DoH, 2001).

This ‘loophole’ was finally closed at the end of 2002 with the introduction of the health professional consent form, which for the first time allowed non-medically qualified health care professionals to obtain consent for surgical procedures.

Notably, the ophthalmology department was the first specialty within the trust to pilot nurse-led consent.

Informed consent and the nurse

The concept of ‘informed consent’ still remains a contentious issue within the elective surgical arena. A review of the literature relating to consent will generate a number of diverse and often complex definitions, depending on the ethical and philosophical paradigm. Therefore, for the purposes of clarity, consent is defined as ‘a patient’s agreement for a health professional to provide care.’

REFERENCES


Patients may indicate consent non-verbally, orally, or in writing (DoH, 2001).

For a signed informed consent form to be valid, three criteria must have been met (Box 1). It is important to note, however, that a signed consent form is not proof of consent – it merely provides evidence that the informed consent process has taken place (Brazier, 2003).

Traditionally, the responsibility for obtaining informed consent from patients for any surgical procedure has lain very much within the medical domain, especially when consent is being obtained on behalf of another medical professional – in this case the operating surgeon. Although the DoH guidelines (2001) state that the health professional carrying out the procedure is ultimately responsible for consent, a review of both current literature (Dimond, 1997; GMC, 1999; NHSE, 2000; RCoPhth, 2001; Semple and Cable, 2003), and the new Code of Professional Conduct (NMC, 2002) indicates that this process is perfectly valid, providing a number of specific criteria are fulfilled. The nurses obtaining the consent must (DoH, 2001):

- Have specialist knowledge of the procedure;
- Have received training in the taking of consent;
- Be aware of limitations to their own knowledge and be able to seek further advice;
- Be subject to audit of their practice.

A potentially problematic area within the informed consent process is that of giving information relating to the potential risks of the planned surgery. The literature suggests that in order for informed consent to take place, the patient must have been given ‘sufficient information’ by the health care professional (Hewetson, 1994; Brennan, 1997). Taylor and Teuten (2001) identify the same problem, using nebulous terms such as ‘substantial risk’ and ‘significant risk’ that would affect the decisions of a ‘reasonable patient’. In an increasingly litigious society, the lack of concrete guidance in this area may seem daunting.

Within our department, the difficulty of informing patients about potential risks and benefits was eventually overcome by presenting local audit data in conjunction with figures from recognised studies that provide statistical information relating to the national average for the proposed surgical intervention, for example the 1997–1998 National Cataract Survey (Desai et al, 1999).

**Audit of practice**

As part of a larger patient satisfaction survey within the day surgery unit, two ‘snapshots’ of nurse practitioner-led consent were carried out, thereby fulfilling the criteria set out within the Department of Health guidelines. The first took place in October 2002 (n=44), and the second three months later, in January 2003 (n=49). For the purposes of expediency, in each case data was collected over a one-month period, and was obtained by the day surgery liaison sister, who telephoned the patients on either the first or second day after the operation as part of a routine follow-up. The nature of the audit required that the instrument (Box 2), which had previously been developed by the trust, sacrifice specificity in favour of gathering a much larger breadth of data relating to the patients’ experience of day surgery as a whole.

As with earlier studies into patient satisfaction with similar nurse-led initiatives (Clinch, 1997; Clark et al, 2000; Sutcliffe and Potter, 2002), this generated some very encouraging results. The aggregate audit data indicated that 98.9 per cent of patients were satisfied with the amount of verbal and written information received, 99 per cent felt that they had received an appropriate type and quality of information in order for them to make an informed decision about the surgery (Fig 1), and between the nurse practitioner, surgeon and anaesthetist, 89.5 per cent of patients cited the nurse practitioner as most helpful in explaining the surgery (Fig 2).

**Shortcomings of the study**

The study had a number of limitations:

- The snapshot data was collected on the back of a generic survey of patient satisfaction, therefore reducing

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**BOX 1. THREE CRITERIA THAT MUST BE FULFILLED FOR CONSENT TO BE VALID:**

- The patients must be competent to make the decision, thus demonstrating ‘capacity’ or ‘understanding’;
- The patients must have received sufficient information to allow them to make the decision;
- The patients must not be acting under duress – consent being obtained voluntarily and without encouragement or coercion.

*(Hewetson, 1994; DoH, 2001)*

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**REFERENCES**


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This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see [www.nursingtimes.net](http://www.nursingtimes.net)
**REFERENCES**


**BOX 2. PATIENT SATISFACTION SURVEY FOR CATARACT DAY SURGERY PATIENTS**

1. Were you happy with the arrangements made for your day surgery appointment? 
   - YES 
   - NO

If no, please give the reasons why:

2. Did you receive enough information about your surgery in your pre-assessment visit? 
   - YES 
   - NO

If no, please state what information you would like to have received:

3. Did you receive any written or printed information about your surgery? 
   - YES 
   - NO

4. Did you receive the right sort of verbal and written information in your pre-assessment visit to allow you to understand your operation before you signed your consent form? 
   - YES 
   - NO

If no, please indicate how we could have improved the way we help you to understand your operation.

5. Who was the most helpful in explaining your operation?
   - Surgeon 
   - Anaesthetist 
   - Nurse practitioner

6. On the day of your surgery were you satisfied with:

<table>
<thead>
<tr>
<th>Level of privacy in the day surgery unit</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Availability of help from the nurses</th>
<th>YES</th>
<th>NO</th>
</tr>
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</table>

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<thead>
<tr>
<th>Length of stay in the unit</th>
<th>YES</th>
<th>NO</th>
</tr>
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7. Would you recommend day surgery to a friend in a similar situation to yours? 
   - YES 
   - NO

If no, please state the reasons why:

Is there any way we could improve the service we provide?

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While the findings’ specificity with regard to consent:

- Both samples were small, which could have led to a distortion of the results;
- Patients were telephoned by a member of staff from the day surgery unit, and may have felt uncomfortable with passing on negative comments. It would therefore be valuable to repeat the study, but this time use an anonymous postal questionnaire with a specifically designed ‘informed consent’ audit tool, possibly employing Likert-style scales and a larger sample. For more definitive answers, a randomised control trial could also be carried out.

**Some conclusions and implications for practice**

With the new health care professional consent form now in place, we are able to offer patients a fully nurse-led pre-operative assessment service with all its concomitant benefits, but without the delays previously associated with seeking consent. The audit indicates that the quality of information being given to patients is of an acceptable standard and is helping to ensure that the individual’s right to autonomous decision-making is being upheld. In addition, the newfound capability of nurses to obtain consent for procedures is having a positive impact in other areas of practice within the department, such as fundus fluorescein angiography (FFA) and nurse-led minor operations sessions.

The debate continues over whether nurses are being asked to extend their responsibilities simply to have them take over somewhat ‘onerous’ tasks that were once within the medical domain. However, this audit takes some steps to substantiate the argument that, if properly supported and implemented, nurse-led initiatives can produce tangible benefits in terms of an improved patient experience, greater job satisfaction for nursing staff, and of course increased efficiency within the organisation.