

Promoting Evidence-Based Nursing Practice:

How can community nursing policy better support a nurse's clinical judgement when clients living with dementia are not able to consent to nursing intervention?

Abstract

Increasingly within the community setting older clients living with dementia are expected to make decisions about their health. Whether it is related to service delivery or choice of provider, these clients often do not have the capacity to make an informed decision due to varying degrees of impaired cognition. Community nursing organisations are encouraged to develop guidelines to assist the nurse in this situation to interpret current legislation related to issues of consent. These guidelines will allow the nurse to broaden their compliance with relevant nursing Acts and Codes for the provision of client care.

This paper presents a review of literature on this issue and suggests guidelines to assist community nursing organisations to implement practice improvements and policy change. Such changes will better support a community nurse's clinical judgement within a mostly autonomous environment when clients living with dementia refuse to consent to nursing or treatment intervention.

Community nurses have been developing ways of 'managing situations' guided by limited nursing policy within the client home environment for many years. One situation prevalent in today's current climate that community nurses face (1) has been the refusal of consent to nursing intervention by clients who live with dementia. When a client refuses to consent to a nursing or treatment intervention, the nurse must possess advanced skills to accurately assess the clients capacity and level of cognition in order to make that decision to be confident that they have met legal obligation and fulfilled their professional duty of care (2,3,4). Carers of clients living with dementia also need to understand these assessment steps to assure themselves of whether their client is making an informed choice (5). The nurse creates opportunity for the client to make decisions if capacity exists while continuing to act as a client advocate who has moral, legal and social obligations to still treat the client with respect and dignity (4). Nurses are encouraged to develop a greater understanding of the relevant legislation related to issues of consent as being fundamental to nursing practice.

While this may seem daunting at the outset, community nurses are best prepared to fulfil this role as they are faced daily with the task of assessing clients capacity to make decisions every time they visit to provide nursing care. The legislative and professional requirements of advocacy, duty of care and the right to refuse care should be foremost in the nurses mind as they strive to provide quality nursing care in a variety of complex and at times less than optimum care environment. Medical advice is not always available at the time a community nurse may require it, therefore the nurse must make a

reasonable decision based on client wishes, his/her own level of nursing expertise, foreseeable risk and relevant policy and legislation in order to provide care which is in the best interests of the client. Although these decisions by the nurse may occur on a daily basis within community nursing organisations, there are no recently published guidelines to assist and direct the nurse in situations related to consent.

One practice strategy that could be supported by a guideline and nursing policy to assist the nurse may be to have the client paraphrase what has been said in order for a level of cognition to be assessed. One other practice may be to conduct a mini mental examination with the client through conversation, which may assist the nurse to assess the ability of the client to make a decision.

The possibility of coercion must be discussed. Coercion, which may be defined as authority without regard of individual wishes (6) is illegal within Australia and community nurses and organisations need to ensure that coercion of any kind is not supported within nursing practice or policy. Attempting to talk a client into agreeing to treatment or nursing care that is perceived as being 'in the client's best interest' is an issue for debate. There are currently no guidelines available to guide the nurse in situations such as this where the nurse is unsure that a truly informed decision has been made. 'Coercion within the health care setting' was presented at the Forth World Conference of International Association of Bioethics in Tokyo in 1998, as this practice is legal in some European countries. This issue needs further exploration and nursing organisations may consider developing clear guidelines to define what constitutes coercion in a clinical setting, particularly where there may be uncertainty regarding capacity.

The Department of Health in the UK developed a reference guide in 2001 for all care workers of people who have diminished mental capacity to lawfully give consent or refuse treatment due to a cognitive impairment (7). The guide sets out in detail the current laws on consent and gives reference to legal cases and good practice guidance from regulatory bodies. Emphasis is given to the importance of the relationship between health professionals, the client and the carer in working together collaboratively in a decision making process where refusal to consent to a nursing treatment or intervention is an issue. However as is the name, the document is only intended to be a guide. Without adequate understanding of relevant legislation and its interpretation, a nurse with good intentions may misinterpret a portion of legislation and assume 'cognitive ability' as something that it is not. Nursing organisations should be mindful that the interpretation of legislation is based on developed and professionally accepted

standards that diminish interpretation based on motivation and self-interest (7).

Within Australia the Office of the Community Advocate has published guidelines for health care professionals which clarifies the common law principle '*consent is not valid if the person is not of sound mind*'. An adult is regarded as incapable of consenting to treatment when they have difficulty understanding the nature and effect of the proposed treatment (8).

While endeavouring to understand current legislation, organisational policy, accepted practice and a notion of what is an appropriate nursing decision for clients who live with dementia and refuse to consent to nursing intervention or treatment, I have developed a set of clinical/management guidelines. These guidelines aim to assist community nurses and organisations to further comprehend the prevalence of coercion and how it impacts upon current nursing practice. In addition, I aim to promote motivation to develop and implement relevant nursing documentation, practice improvement and where necessary, policy change. Change is a systematic process, however the focus of the guideline has been on assisting the nurse to incorporate new ways of working so nurses can own the process, set time lines and connect important clinical aspects of care with organisational frameworks (9,10,11).

Guidelines For Consent For Persons With Diminished Capacity

It is suggested that:

- A suitable, validated tool for assessing and determining mental capacity is identified e.g. a tool that tests the clients cognitive ability and orientation to time, place and person, ie mini mental examination.
- Ongoing nurse education be implemented to foster the nurses' skills using these assessment tools.
- A systematic review of state and federal legislation be undertaken to gain an understanding of broad arbitrary statements and common legislative language.
- Discussion be promoted to clarify coercion techniques and to reduce their prevalence in the community setting.
- Update and review current nursing practice and policies related to consent, refusal of care by client/carer, advocacy, coercion and cognitive ability assessment skills.
- Establish time lines for discussion, education of nursing staff, implementation of new and/or updated policies and a review and measuring of practice changes.
- Create evaluation forms for use by nurses, clients and carers to feedback any evidence if improved communication and care for a client living with dementia.

Conclusion

These guidelines offer community nursing organisations a creative approach in evaluating care for clients living with dementia who refuse to consent to nursing intervention or treatment. The use of an evaluation form can measure the effectiveness of change outcomes and be included in quality management systems for the future.

Issues related to nursing and caring for clients living with dementia can be as clear as they are complex. By initiating the above guidelines into an organisational or a regional working party, many issues may be raised for debate, and guidelines and policy developed that can then better support nurses in the future.

The main aim is to provide quality nursing care for clients with dementia and the adoption of these guidelines to practice would greatly enhance outcomes for this group of vulnerable clients.

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