Peripheral intravenous cannulation and patient consent

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Summary
As nurses enhance their skills by taking on more tasks previously carried out by doctors, the need arises to be aware of consent. All nurses must have the capacity to ensure safe professional practice; consent is only one aspect of the enhanced role. The author reviews this issue through an exploration of peripheral intravenous cannulation.

Peripheral cannulation is one of the many clinical skills increasingly being undertaken by registered nurses, and it is the second most common invasive procedure for patients in hospital (Dougherty 1996). The reduction in junior doctors’ hours during the early 1990s was one reason why registered nurses started to take on enhanced roles (Dowling et al 1996). Nurses practising enhanced clinical skills that are taught post-registration need to be aware of all factors relating to the new skill. The Code of Professional Conduct (NMC 2002) outlines all aspects of professional accountability and provides guidance for professional practice. Allied with enhanced skills is the need for competence and support in practice to ensure good quality, effective care which is delivered by safe and accountable practitioners and with patients’ consent (Dimond 1995).

Any aspect of care delivered to patients requires their consent, but that consent is often assumed. However, where there is a need to practise a clinical skill that is not usually associated with one profession, it is crucial that the patient is aware of this and, through consultation, in a position to give informed consent, thereby requiring registered nurses to understand the concept of competence in relation to decision-making and consent. The Code of Professional Conduct (NMC 2002) states that, usually, the person undertaking the procedure should be the person to obtain the (patient’s) consent. In the context of peripheral IV cannulation, consent could be verbal or active. For example, the patient participates in the procedure by rolling up his or her sleeve or offering the preferred arm to the registered nurse.

Scholefield et al (1997) reviewed the principle of consent, and outlined the process of gaining legally valid consent, thus ensuring a systematic and consistent process. For consent to be legally valid, the patient must:
- Have capacity in law.
- Be properly informed beforehand.
- Give consent voluntarily.

Capacity in law Capacity may be variable, and while a patient might be deemed competent to make a simple decision, he or she may be assessed as not having capacity where a decision is more complex. With the launch of the Adults with Incapacity (Scotland) Act (SE 2000) this process of assessing capacity was central. Registered nurses must be aware of their own accountability in seeking and gaining consent, allied with their professional conduct. Delegation from another is not sufficient (GMC 1998, NMC 2002).

The Reference Guide to Consent for Examination or Treatment (DoH 2001) provided guidance on English law; the principles governing valid consent appear consistent with Scottish Law (Scottish Office 2001), and are in line with the Human Rights Act 1998 (Home Office 2000). The Scottish Office reference paper (Scottish Office 2001) stated that for consent to be valid, it must be given voluntarily by an appropriately informed person (in Scotland, adults over 16 years of age) who has the capacity to consent to the intervention in question.
Information In discussion with the patient, the practitioner must present a balanced view of options and the requirement for informed consent. Patients should also be given enough appropriate information to enable them to make their choice. Appropriate information means taking account of patient preference, age and language. Practitioners must be aware of appropriate timing for giving information; for example, if it is done immediately before seeking consent for a procedure this may not allow the patient time to absorb the information before making a decision. Also, when supporting information is provided, practitioners must ensure it is appropriate for that patient. Patients can indicate their consent orally or in writing. For peripheral IV cannulation, verbal consent is considered acceptable.

Information given about cannulation should inform and educate: practitioners must include details of the procedure and post-procedure care. Many patients express anxiety about this type of procedure, so information should also aim to reassure. This information will ensure patients are fully aware of their care needs and also of any relevant potential risks with the procedure and with the cannula in situ.

The Royal Infirmary, Lothian University Hospitals NHS Trust’s policy advocates reviewing and re-siting each cannula every 48 hours. Education must include apprising patients of their responsibilities to report pain, swelling, discomfort, redness, leakage or loose dressings, as well as giving advice about not touching the site/cannula, and care when dressing/undressing. If it is sited in an area of flexion, the patient must be advised to minimise movement. Many patients think they are being left with a needle in their arm, so each nurse has a responsibility to ensure that educating the patient includes giving information about the cannula. This is crucial when ensuring patients comply with the procedure and after care, thus ensuring safe and effective cannulation practice.

Voluntary consent To be valid, consent must be given voluntarily and freely, without influence or undue pressure to accept or refuse treatment. The patient has the right to refuse treatment at any time, and it is generally recommended that health professionals presume that each patient has capacity (GMC 1998).

If a patient is offered information (verbal and/or written) and declines, it is good practice to record this in his or her notes. This ensures that should evidence be required about the patient’s informed consent, the registered nurse can produce the record. Practitioners should remember that written consent merely serves as evidence of consent. If the elements of voluntariness, appropriate information and capacity have not been satisfied, a signature on a form will not make the consent valid (GMC 1998).

Competence

To remain on the effective register, registered nurses must keep their knowledge and skills up to date and participate in learning activities that develop competence and performance (NMC 2002). Teaching peripheral IV cannulation, or any other clinical skill, must address competent practice and accountability as underpinning components of safe practice (Gray 1997). Teaching the theory of peripheral IV cannulation must also cover the venous and arterial system and structures of the arm. Educational preparation should also include staff responsibilities, infection control, vein and patient criteria in selecting an appropriate site, and the process for documenting and monitoring. Regular practice in enhanced clinical skills is essential and requires nurses to reflect and self-monitor their own practice. The author’s trust advocates self-appraisal every three months. Along with self-appraisal it is essential to have a mechanism of support and supervision, as well as robust appraisal systems.

Support

Any acquisition of enhanced skills must be underpinned by a relevant and research-based educational programme, ensuring effective knowledge, and supported in practice through appropriate supervision. The clinical governance agenda drives accountability and risk management processes and safe systems of working. Staff should choose to undertake these enhanced skills where they can perceive benefits to patients and their care (NMC 2002). Staff appraisal carried out systematically and focusing on role development enables this process too. The Bristol Royal Inquiry Report (2001) noted that any clinician carrying out a clinical procedure for the first time must be supervised directly by colleagues with the necessary skill, competence and experience, and should continue to be supervised until such time as the relevant degree of expertise has been acquired. Staff will also require effective ongoing support to minimise risks and enable evidence-based practice.

Effective care

Wright (1995) advocated that nurses should question whether the enhanced role is relevant and will improve patient care, and whether the ward environment will support these skills. The author’s trust undertook a review of the competency and relevance of these roles, and registered nurses considered peripheral IV cannulation to be a relevant procedure to consider in this context. The Code of Professional Conduct (NMC 2002) focuses on enhanced roles and accountability, and asks
nurses to consider if they are acting in the best interests of their patient. The code clearly advocates that every nurse has a responsibility to deliver care based on current best practice and evidence and, where possible, from validated research. Land et al (1996) proposed that as healthcare reforms emphasised the need for flexibility, all health professionals must demonstrate clear and positive patient outcomes.

**Accountability**

Dimond (1995) clearly described accountability as an integral part of professional practice, requiring sound clinical judgement and decision-making skills. Rowe (2000) further explored accountability and noted its fundamental nature to all practice. Accountable practitioners must consider all aspects of their practice. In peripheral IV cannulation this would encompass adhering to sound infection control principles and their employer's policies. Further, registered nurses must be prepared to defend their actions or any omissions (NMC 2002), in the four areas of accountability:
- Patient.
- Nursing and Midwifery Council.
- Law, both criminal and civil.
- Employer.

The enhanced role challenges registered nurses to consider their limitations as well as their abilities, and to make these known.

**Conclusion**

When registered nurses use their enhanced skills in peripheral IV cannulation, there are benefits for patients: closer supervision and monitoring, prompt recognition of potential complications and management of cannula and/or site in response.

It is crucial that effective records are maintained where nurses are using advanced skills. (UKCC 1996, now incorporated into the NMC Code of Professional Conduct 2002). This is even more essential where other health professionals share roles. Patient records, preferably shared or unitary, must include the following information: site, size of cannula, date and time of insertion, reason for insertion and the signature of the person who undertook the procedure, thus underpinning the consent process. Regular review of the site, the cannula and the need for cannulation must be encouraged and documented, in keeping with good practice.

Gaining patient consent in what may appear a simple clinical procedure is essential, both to ensure patient compliance and assessment of necessity for each cannula insertion.