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Original Article

An audit cycle of consent form completion: A useful tool to improve junior doctor training

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ABSTRACT

Background: Consent for surgical procedures is an essential part of the patient's pathway. Junior doctors are often expected to do this, especially in the emergency setting. As a result, the aim of our audit was to assess our practice in consenting and institute changes within our department to maintain best medical practice. **Methods:** An audit of consent form completion was conducted in March 2013. Standards were taken from Good Surgical Practice (2008) and General Medical Council guidelines. Inclusion of consent teaching at a formal consultant delivered orientation programme was then instituted. A re-audit was completed to reassess compliance. **Results:** Thirty-seven consent forms were analysed. The re-audit demonstrated an improvement in documentation of benefits (91–100%) and additional procedures (0–7.5%). Additional areas for improvement such as offering a copy of the consent form to the patient and confirmation of consent if a delay occurred between consenting and the procedure were identified. **Conclusion:** The re-audit demonstrated an improvement in the consent process. It also identified new areas of emphasis that were addressed in formal teaching sessions. The audit cycle can be a useful tool in monitoring, assessing and improving clinical practice to ensure the provision of best patient care.

KEY WORDS

Audit cycle; consent form completion; consenting in surgery; junior doctor training

INTRODUCTION

Accurate and timely informed surgical consent is the first essential safety process element for any surgical procedure. The consent process has several important components, and deficiencies or absence of any one of these can contribute to surgical errors. Consent should be viewed as a critical safety process that aims to provide the safest and best quality surgical care for patients. National standards exist and provide guidance on the best practice when it comes to obtaining consent for surgical procedures.[1,2]

It is important to recognise that seeking consent for surgical intervention goes beyond obtaining a signed and

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completed consent form: It is the process of providing the information that enables the patient to make a decision to undergo a specific treatment. However, a suitably completed form filed in the patient's case notes is the best available proxy for documented evidence that all elements of consent have taken place.

One of the roles of clinical members of the surgical team is to ensure that consent has been adequately taken. Patients must understand their diagnosis and prognosis, the purpose of the intervention, the benefits and potential risks and any existing alternatives including non-operative and conservative measures. The discussion of risk must include ones "inherent in the procedure; however, small the possibility of their occurrence, side effects and complications."[1] The patient should also be aware of plans for follow-up, and for additional surgical and other relevant interventions. It is also good practice to include information about anaesthesia.[2]

Given the volume of information, the clinician is required to convey to the patient, it is important that the consent discussion is undertaken using patient-friendly language that is free of medical jargon, and if possible include the aid of written information (usually in the form of a patient information leaflet). In the ideal setting, there should be a period of time before the consent discussion and procedure to allow for the patient to reflect and digest the information provided to them, and clarify any doubts that they may have about the procedure.

National guidelines state that either the person who is providing, or is actively involved in, the provision of treatment should obtain consent. As a result, consent in the trauma setting is frequently delegated to more junior members of the team. This is acceptable as long as the delegate has clear knowledge of the procedure and the potential risks and complications to counsel the patient adequately. Although knowledge of consent is a requirement of the undergraduate curriculum in the UK according to the General Medical Council, the practice differs from the theory especially with a small speciality such as orthoplastics trauma, and the majority of experience and teaching is "*ad hoc*" and received "on the job."

Clinicians have a duty to maintain patient trust, and by extension, ensure they are suitably prepared for the role of consenting. It is a well-known fact that current junior trainees are not as exposed to the variety of surgical procedures as their senior colleagues would have been, thus presenting an opportunity for departments to take the initiative and utilise innovative methods to provide training to ensure juniors are adequately equipped to obtain consent. As a result, the aim of our audit was to evaluate the process of consent in the trauma setting in busy regional Orthoplastic Hand Unit. We also aimed to improve this process by providing structured consultant delivered orientation programme for new juniors rotating into the department. We then re-audited our practice to determine the effectiveness of our intervention.

METHODS

Audit one

Patient records of all new trauma referrals seen by the on call doctor at senior house officer (SHO) level (i.e., not in higher speciality training; SHO levels include those 3 and 4 years post-graduate: Our unit does not employ more junior staff) undergoing surgical intervention between March and May 2013 were reviewed prospectively and compared to criteria identified in national guidelines on consenting patients for surgical procedures. The following domains were analysed for accuracy of completion: Patient demographics (name, date of birth and hospital identification number), procedure details (operation name and laterality of procedure), clinician's details (printed name, signature and date, role), patient's details (printed name, signature and date), benefits, risks, potential additional procedures, anaesthetic type, confirmation of consent (if consent was performed >24 h before procedure date), and whether or not the patient was offered a copy of their consent form (it was assumed not if no box was ticked to specify the patient had refused a copy or if the carbon copy was filed in the notes).

Audit two

Results from the initial audit were disseminated to the department reinforcing the deficiencies highlighted. A formalised consultant delivered orientation programme teaching for all new junior doctors rotating into the department on a 6 monthly basis was formalised and conducted. Another audit was carried out 1 year from the original audit, and therefore at the interval of 5–6 months after the teaching, to determine the efficiency of this intervention and to identify additional areas for improvement.

RESULTS

A total of 37 and 39 sets of patient notes were selected at random from the Hand Unit's outpatients' clinic for the

first and second audit cycle, respectively. All 74 consent forms analysed consisted of consent form 1, were legible, and required no interpreter. The full set of results can be seen in Tables 1-4.

With regards to patient demographics [Table 1], 100% of the consent forms had the patient's name, date of birth and unique identifier (hospital number or NHS number) documented.

Documentation of details of the intervention [Table 2] was present in 100% of the cases for the procedure name and laterality in both cycles. Ninety-one percent of forms had benefits of the procedure documented in 2013 compared to 100% in 2014. There was no (0%) documentation of additional procedures such as need for blood transfusion, drains or application of splints in 2013 but this increased to 7.5% in 2014. Anaesthetic type (general anaesthetic, local anaesthetic or local with sedation) was documented in 100% of forms in 2013 versus 92.5% in 2014.

Table 3 shows the findings on documentation of the rest of the consent form between the two audit cycles: This includes both patient and clinician printing, signing and dating the form, the clinician's role, whether a copy of the consent form was offered to the patient. The consent form was filed in 100% of notes in 2013 (and 94.8% in 2014; of the 39 sets of notes randomly selected in 2014, two were found to have missing consent forms.

Table 4 shows the data found on confirmation of consent; this was applicable in twenty forms in 2013, and 15 in 2014. Confirmation of consent was sought in 46% and 13%, respectively.

Table 1: Patient demographics

Criteria	*2013 (%, n=37)*	*2014 (%, n=37)*
Patient name	100	100
Date of birth	100	100
Unique identifier	100	100

Table 2: Procedural details

Criteria	*2013 (%, n=37)*	*2014 (%, n=37)*
Procedure name	100	100
Laterality	100	100
Benefits	91	100
Risks	100	100
Additional procedures	0	7.5
Anaesthetic type	100	92.5

Table 3: Other

Criteria	*2013 (%, n=37)*	*2014 (%, n=37)*
Patient		
Printed name	65	30
Signed	100	100
Dated	95	56.8
Clinician		
Printed name	100	100
Signed	100	100
Dated	100	100
Role	100	94.6
Copy of consent form offered to patient	15	13.5
Legibility	100	100
Consent form filed in notes	100	94.8*

*n=37/39

Table 4: Confirmation of consent

Criteria	*2013 (%, n=20)*	*2014 (%, n=15)*
Clinician		
Printed name	46	13
Signed	46	13
Dated	46	13

DISCUSSION

Given the importance of consent, this audit and re-audit were carried out to evaluate the standard of consent form completion in a regional Orthoplastic Hand Centre.

Recommendations made as a result of the 2013 audit included incorporating the consent process into the junior doctor departmental orientation programme and teaching, as well as increasing awareness of departmental efforts to increase standards.

A standard formalised consultant delivered junior doctor teaching during their orientation programme has proven to be useful measure in ensuring that adequate training is delivered. Not only are juniors taught the basic principles of the procedures in which they are expected to be able to counsel patients on, but also they have the opportunity to clarify doubts and expectations with a consultant. This session has had positive feedback from doctors and nursing staff alike.

Findings comparing 2013–2014 can be seen in Tables 1-3. The key areas of improvement between 2013 and 2014 included an increase in the documentation of benefits (91–100%) and additional procedures (0–7.5%). However, there were deficiencies in completion of essential demographical data such as patients printing their name (65–30%), accurate dating of the consent forms (95–56.8%), obtaining confirmation of consent (46–13.3%) and offering a copy of the consent form to the patient (15–13.5%).

Although progress has been made following the first audit, there are still areas that can be improved to ensure that we are in line with national guidelines. For example, clinicians should be reminded to encourage patients to print their name and date the consent form. This can be checked as part of the WHO Surgical Safety Checklist[3] in the anaesthetic room by the operating department staff. This exercise has medico-legal implications, as this information that may be used later on in litigation cases.

The importance of accurate documentation of the consent process has been highlighted by in a review by Bhattacharyya *et al*. on the medico-legal aspects of consent in orthopaedic surgery. They found that measures, including accurate documentation and filing of consent in patient notes, were associated with a decreased indemnity risk.[4]

According to national guidelines, once the consent form is signed, a copy should be given to the patient for reference and reflection in addition to a patient information leaflet. This problem is not uncommon; other audits in the literature cite this as a potential area for development.[5] Many hospitals have consent forms which come in a paper and carbon copy form, of which one is given to the patient. Given the low rate of patients receiving a copy of their consent form, on top of encouraging clinicians to offer a copy to the patient, a possible remedy is to ensure that it is included as part of a discharge pack (which includes the discharge letter or summary and any takes home medications).

Confirmation of consent is an important exercise that is often overlooked in many busy departments. It should be done if there has been a delay between the consenting process and the actual intervention. It demonstrates that the procedure has been rediscussed with the patient and any changes in the patient's circumstances are noted.

Limitations with this audit cycle include the varying degree of experience SHOs have SHO training is usually of a 2 years duration, so at any one point, some will be more experienced than others. We have also not adjusted for SHOs who may have previously undertaken work with a similar job description in another unit. Attempts to mitigate this include repeating the audit at 1-year intervals, and at the end of the job rotation so that the teaching and experience are as consistent as possible among those working in the department.

We recommend that the audit be repeated at an annual interval, with the above measures taken into account, to continue assessing and improving our practice. It may also be prudent to further clarify the seniority of the SHO consenting, to try to determine if this has an impact on the results. However, even with the potential for minor differences in seniority and experience between the SHOs, we feel that the practice of accurate documentation is something that even the most junior doctor can aspire to and is not something that should interfere with improving practice.

CONCLUSION

We have, using the process of an audit cycle, identified and changed our practice in consenting patients for trauma procedures. Through minor changes such as teaching and staff awareness, we were able to improve our performance in accurate completing of consent forms to ensure compliance with national guidelines.

The consent exercise is an important information giving process to the patient, which should be accompanied by meticulous and accurate documentation. Failure to achieve this renders the clinician to legal implications, but more importantly can compromise the high standard of patient care that we all aim to achieve.

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Conflicts of interest
There are no conflicts of interest.

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