Engaging staff in the informed consent process

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Staff can have a valuable role in the delivery of patient-focused care by assisting in the informed consent process.

The informed consent process involves three steps to educate a patient about the risks, benefits and alternatives to a proposed treatment. The first step involves a conversation between the treating OMS and the patient. In the second step, the patient acknowledges their understanding and acceptance of the information discussed with the treating OMS by signing an informed consent form. In the third step, the treating OMS documents the patient's participation in the informed consent process in the patient's chart.

Step 1. A clinical conversation

Each patient is unique due to his or her medical history, presenting condition and the goals of treatment. Frequent topics of the informed consent conversation include:

- Diagnosis
- Proposed treatment, with anesthesia options
- Benefits of the proposed treatment
- The risks and potential complications of the proposed treatment and anesthesia
- The risks of refusing the proposed treatment
- Treatment alternatives, including the risks and benefits to foregoing treatment

The informed consent conversation also provides an opportunity to educate the patient regarding the impact that any pre-existing conditions or medications may have on the proposed treatment and review the anticipated pre- and post-operative instructions.

To help ensure the patient fully understands the procedure and potential risks, it is recommended to conduct all conversations at the intellectual level of each patient and to provide a qualified interpreter, if needed. Some patients may benefit from supplementing the conversation with visual aids and other patient education resources. To assess the patient's understanding of the information shared, the OMS can ask the patient to summarize the discussion and provide the patient an opportunity to ask questions about the proposed treatment.

Step 2. Patient acknowledgement

After the OMS performing the procedure discusses the risks, benefits and alternatives with the patient, the patient's signature on a consent form serves to acknowledge their understanding and acceptance of the information discussed. The informed consent form can be customized to meet the potential risks for each patient given the specifics of their procedure and their presenting condition.

Some practices require that a paper copy be signed in the office and witnessed by the OMS and staff. Other practices utilize electronic consent forms, which a patient can sign even when they are not in the office. Whichever method is used, keep in mind that the patient should sign the consent form after the informed consent discussion is complete, prior to the procedure and before any anesthesia, mind-altering medications or narcotics are administered. To ensure consistency, each practice should establish and follow a protocol for consent form execution and the role of the staff member as a witness to a patient's signature.

One common risk management question is – does a properly executed informed consent form expire after a specific date? The general answer is that – absent an office policy or other requirement – informed consent forms do not expire as long as the risk, benefits and alternatives to the proposed treatment have not changed. In scenarios where execution of the informed consent form and the treatments are temporally separate, some practices may have the patient sign a new consent form or may amend the existing form with the patient's dated initials.

Whether or not a new or amended consent form is used, the treating OMS documentation can be used to confirm that the patient participated in the informed consent process; that the patient continues to acknowledge the risks, benefits and alternatives to the proposed treatment;

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and the patient desires to proceed with the proposed treatment. This clinical documentation provides a basis to respond to future patient allegations that informed consent was not obtained.

Step 3. Clinical documentation

While no one can predict future patient allegations related to their treatment or the informed consent process, contemporaneous clinical documentation of the patient's participation in the informed consent process can be used to support your patient education efforts and treatment decisions.

Clinical documentation captures the presentation, examination findings and a clinical differential diagnosis that forms the basis for a patient's treatment plan. In the context of the informed consent process, documentation in the clinical record can include that the patient verbally accepted the treatment plan and signed the consent form to acknowledge the risks, benefits and alternatives for the proposed treatment and that the patient wishes to proceed with the proposed treatment.

Additional documentation topics to consider include the use of any patient educational aides, any direct questions or quotes from the patient and the identity of any individuals who were present with the patient during the informed consent discussions.

Staff's role in informed consent process

Office staff can play an important role in assisting with the informed consent process by assuring that accurate and complete patient information is available for the OMS. In the context of the informed consent discussion, OMS staff can:

- Review the referral form for completeness before an appointment is scheduled and by contacting the referring provider if any questions about the purpose of the referral arise.
- Request, when the appointment is scheduled, if the patient would prefer that an interpreter is available for their appointment.
- Provide the health history form and request that it be returned before the first scheduled appointment in order to improve the accuracy of identifying a patient's medications and healthcare providers.
- Review the health history for missing information such as medication names without doses, surgeries or treatments without dates, or the contact information for the patient's other healthcare providers.
- Request that the patient provide a verbal summary of the pre- or post-operative instructions.

Regarding the patient acknowledgement, office staff can support consent form execution by utilizing forms with identified risks for the most common procedures and by customizing the informed consent forms to meet each patient's clinical presentation.

OMS staff can support the third step of the informed consent process by supplementing the treating doctor's entries regarding the patient's participation in the informed consent process. For example, staff could document any patient questions regarding the supplemental educational materials or the preoperative instructions. When documenting these patient interactions, consider having staff include direct quotes from the patient as these quotes may provide insight into the patient's understanding of the informed consent process.

OMSNIC resources

OMSNIC offers more than 45 procedure-specific informed consent forms for download including forms related to cosmetic, craniofacial, dentoalveolar, implant, jaw joint, nerve and oral pathology surgeries. All OMSNIC informed consent forms are regularly reviewed for clinical relevance and patient-friendly language.

A few recent additions to the procedure-specific informed consent forms included expansion of the nerve injury risk descriptions, the addition of future treatment risks and new informed consent forms for cleft lip, cleft palate, cosmetic and tori removal procedures. A complete list of the current OMSNIC forms and resources is available at OMSNIC.com/patient-safety-risk-management. ■

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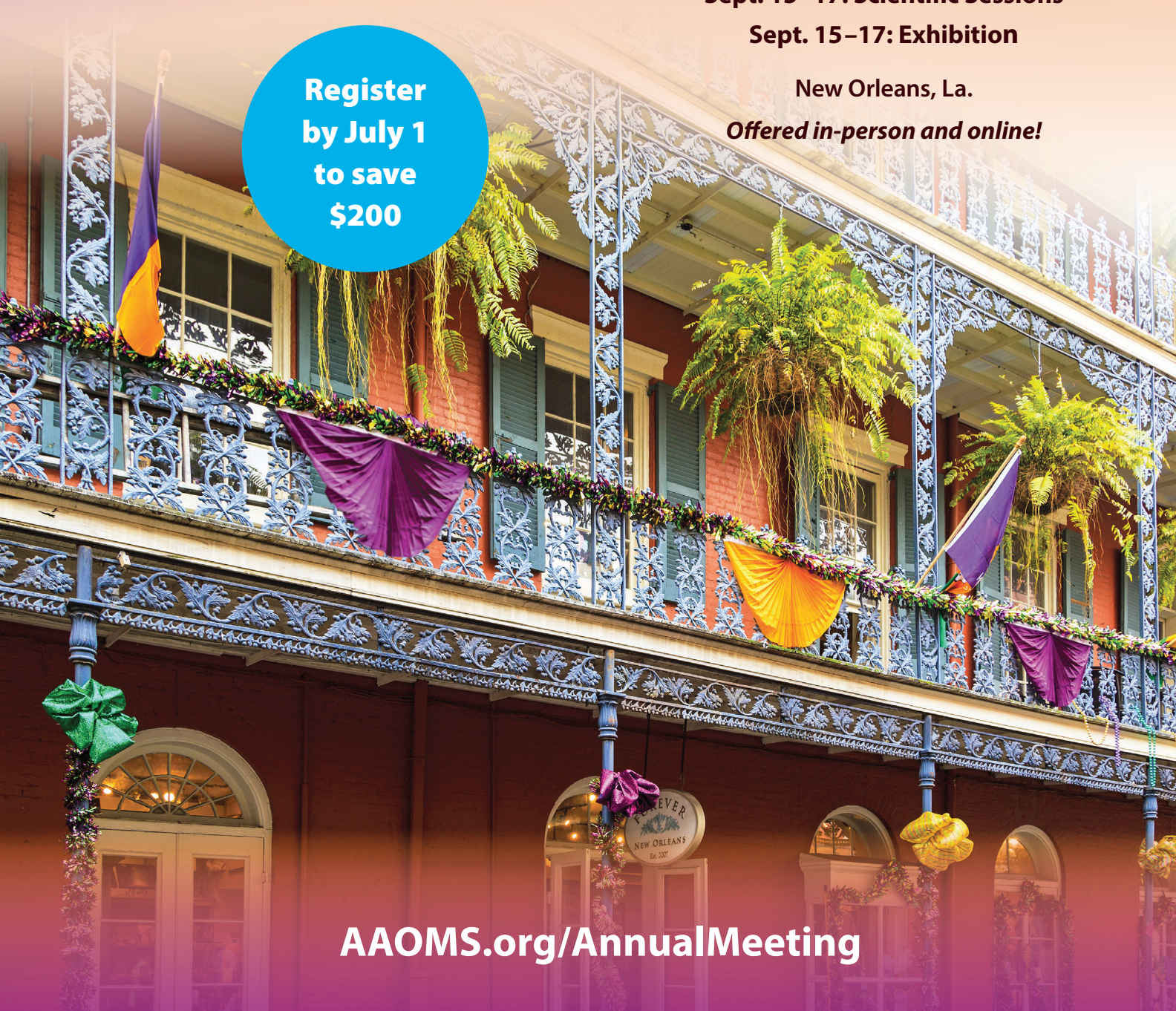

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