A clearer, more robust surgical consent process

A large Chicago-area health system has built a clearer, more robust process for resolving any discrepancies in the surgical consent prior to the day of surgery. Consent discrepancies are a risk factor for wrong-site surgery.

“We realized that by the time the patient arrives in the surgery area, it is too late. Most of the work is done preoperatively,” says Beverly Beine, BSN, MS, RN, NE-BC, vice president for perioperative services, for Evanston, Illinois-based NorthShore University HealthSystem, which has 4 hospitals and performs about 40,000 procedures a year.

After a couple of near misses in ophthalmology, a team of nurses began working on a quality improvement project to ensure consistency among the signed consent, the surgical schedule, and the surgeon’s update note.

“We looked at the whole process—what were the key failure points?” she says.

Surgical scheduling is centralized for all 4 hospitals. Scheduling requests are called in, faxed, or for some offices, scheduled via computer. A challenge is that consents do not follow a standard workflow. Some offices submit them via Epic, the health system’s electronic health record. Others fax the forms. Or patients bring them to their preop appointment.

After the QI project was completed and changes introduced, within a year, consent discrepancies fell from about 8% of cases to about 0.3%.

A refined process

Among the changes in the consent policy:

- Consents for elective procedures must be received in the preop area at least 24 hours before surgery.
- The attending surgeon, not the physician assistant (PA), must either obtain the patient’s consent or enter the consent order in Epic.
- Using Epic, which all surgeons’ offices can access either directly or through a web portal, surgeons can enter the consent order as soon as the patient encounter is completed and append it to the patient’s record. When the patient arrives for surgery, the consent order is released, and the nurse can perform the formality of having the patient sign the consent form.

“We are seeing some surgeons doing them more than 24 hours in advance, which is good,” Beine says.
- The consent information is verified with the patient during the preop phone call, again on admission, and again with the patient during the surgical site marking.
- Abbreviations were reviewed to make sure they were standardized and added to the list of those approved. Some, such as TLIF (transforaminal lumbar interbody fusion), were sent to the health information management department for approval.
- On the day of surgery, patients are not taken to the procedural area until any discrepancies in presurgical documents are resolved.

During the Universal Protocol to verify the patient’s surgical site before the procedure, the team checks again to make sure the consent order matches the OR schedule
and the surgeon’s update note.

“If those 3 elements are not consistent, we stop the process,” Beine says. “Phone calls are made, and the information is clarified until we have the correct information.”

A learning curve

As with any process change, there was a learning curve. NorthShore has a number of midlevel providers, such as PAs, who work with the surgeons in preparing patients for surgery.

The Surgical Quality Committee was instrumental in getting the buy-in of surgeons because they analyze near misses as part of the peer review process.

“They got the information out,” she says. “We shared it with the staff so they would understand why we were doing this.”

The administration supported the decision not to take patients to the procedural area until discrepancies are resolved.

Though there are still some challenges, Beine says, “At this point, I don’t believe the surgeons would want to go back. It’s becoming part of their workflow.”

She adds: “The focus really is on creating a culture of safety. We drove that message home with the surgeons, anesthesia, and the OR staff.”

—Pat Patterson