2014 Audit of Patient Information & Consent

Miss Emma Court

General Surgical Registrar, Severn Deanery

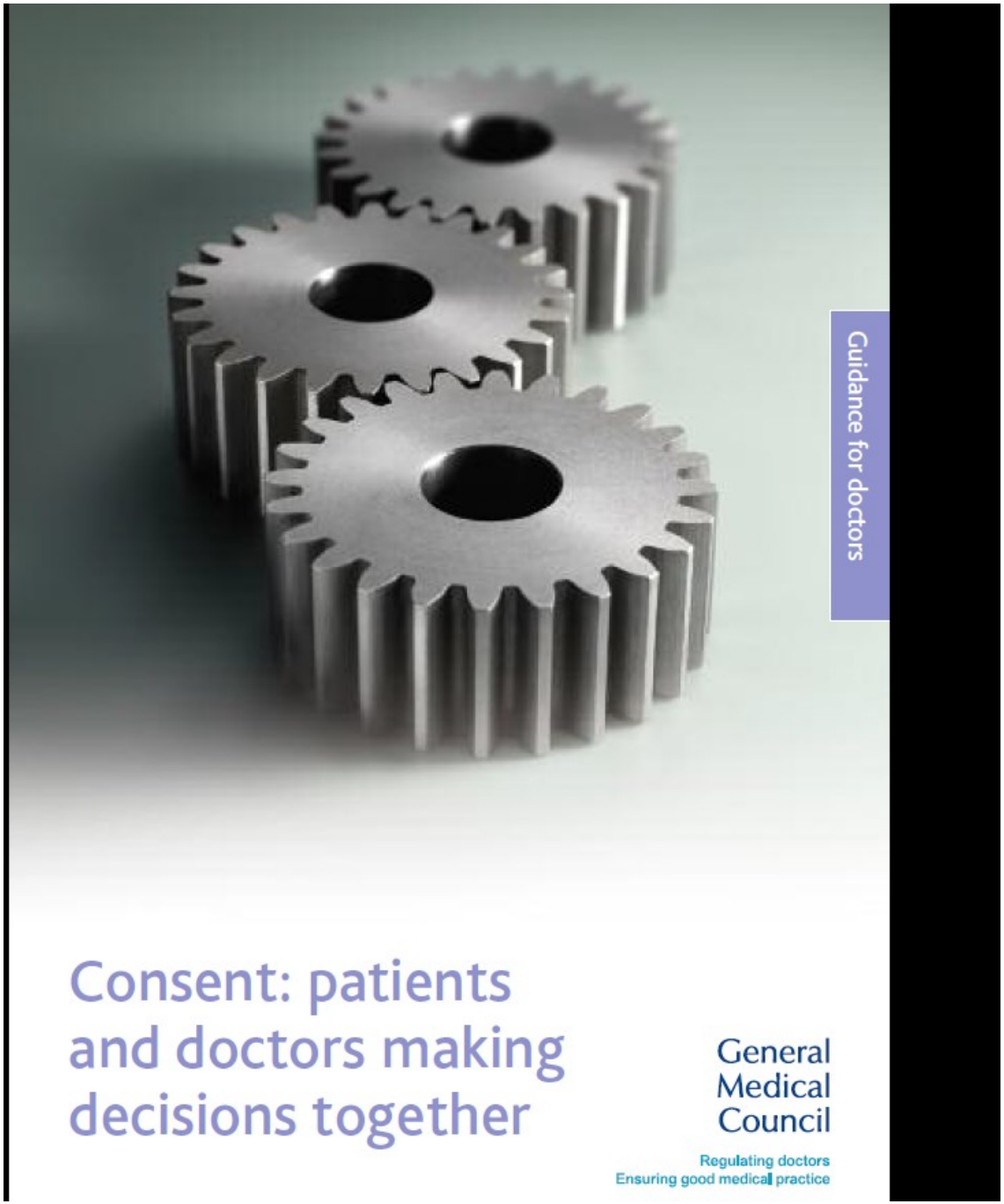
- General legal & ethical principle
- Valid consent should be obtained from a patient before they are treated

Consent for Blood Transfusion: guidance stated in

British Committee for Standards in Haematology guidelines

NHS Quality Improvement Scotland

Handbook of Transfusion Medicine



Patient information and consent

paucity of data or published research (some examples of UK publications below)

- **Court EL et al Trans Med 2011**
- **164 patients**
  - **59% said they received explanation around needing a transfusion**
  - **only 27% aware of an information leaflet**

- **Davis R et al Trans Med 2012**
- **110 patients**
  - **61 recalled giving consent, 22 would have liked more information**
- **123 doctors, nurses & midwives**
  - **83 felt that patients not given sufficient information about transfusion**

Advisory Committee for Safety of Blood Tissues Organs (SaBTO)

- Concern that practice around obtaining informed consent for blood transfusion is highly variable in the UK

- Following stakeholder consultation SaBTO developed guidance in 2011 stating that

  - Valid consent for blood transfusion should be obtained and documented in the patients' clinical record by the healthcare professional

What entails valid consent for Blood Transfusion?

1. Informing patient of indication for transfusion
2. Explaining risks and benefits
3. Discussing alternatives to transfusion
4. Obtaining a signature from the patient

Do not need written consent for transfusion

Why did we do this audit?

- To assess to what extent hospitals document the provision of information on blood transfusion to patients
- To assess to what extent and by what means the patient's consent to be transfused is captured in the medical record
- To survey patient awareness/recall of the information supplied
- To assess the knowledge of those providing information and taking consent, in respect of the local availability of information and the sort of information given
- To report on extent to which current practice is in line with SaBTO guidance

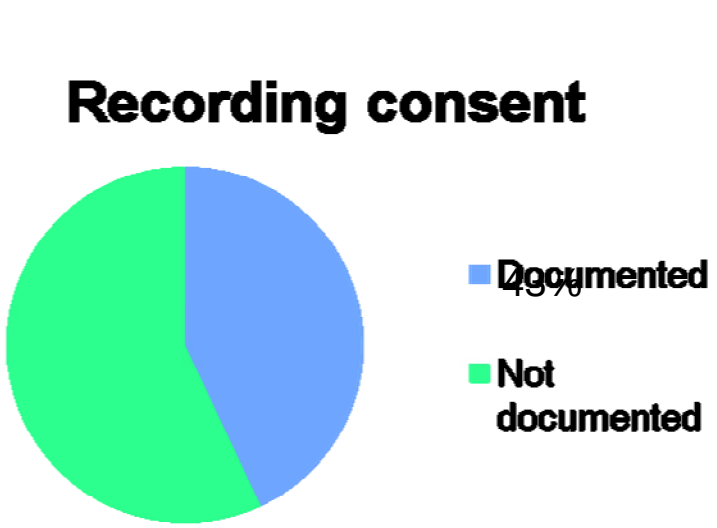
Method and sample size

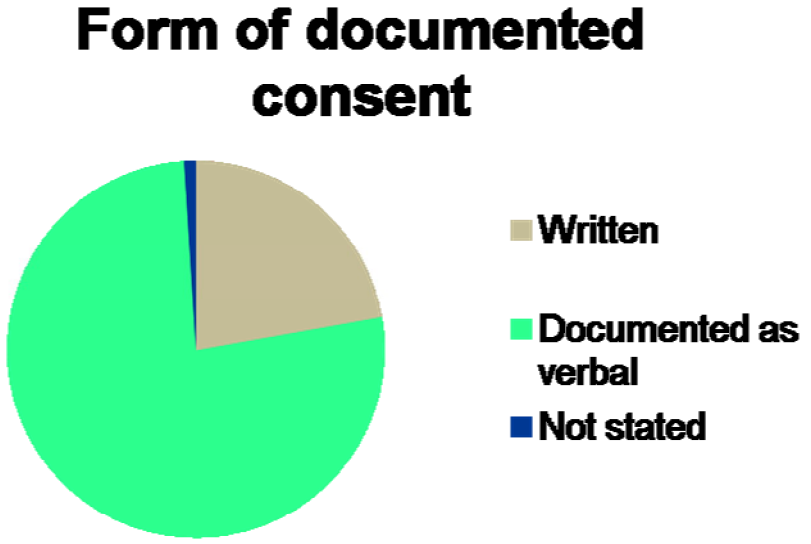
- Sites completed an organisational audit around Trust policies
- Patient Audit - Sites identified 2 patients per week for 12 weeks, elective adult admissions only
  - Site Auditor visited blood bank to identify patients and visited the clinical area about an hour after the blood was collected
  - Auditor checked that patient suitable to be approached. If patient deemed not suitable, auditor moved on to next patient
  - The auditor reviewed casenotes
  - gave the patient a questionnaire and
  - gave a questionnaire to healthcare member obtaining consent.

Results – Organisational audit

- 141 sites completed the organisational survey
- 85% (120/141) Trusts have a policy on consent for transfusion
- 89% (125/141) have a policy on the provision of written information
- 18% (24/141) require written, signed consent for transfusion
- 93% (131/141) require staff to inform patients about risks, benefits and alternatives
- 77% (108/141) routinely provide patients with written transfusion information

Casenote audit (2784 cases) from 164 sites
Results – all specialties





In over 80% of cases, consent was obtained by doctors; 72% were FY1 and FY2 trainees

Clinical specialties

- Medical 42%
- Haem/Onc 20%
- Surgical 33%
- Obstetric 4%

Surgical Patients

- 164 sites provided patient data on 2780 cases for the casenote documentation audit, of which 916 (approx. one third) were surgical patients

- 743 (81%) of the 916 surgical patients completed a patient questionnaire

Comparison of practice between specialties

Audit of case note documentation

	Medical (n=1172)	Surgical (n=916)	Haem/onc (n=570)
Indication for transfusion documented	83%	80%	77%
Consent for transfusion documented	36%	48%	44%
Documentation that written information given	17%	16%	25%
Documentation that risks explained to patient	20%	23%	26%
Documentation that alternatives explained	15%	19%	16%

Patient recall based on completed questionnaires from 2137 patients

	Medical (n=874)	Surgical (n=743)	Haem/onc (n=518)
Patient recalls benefits being explained	65%	61%	82%
Recalls giving consent for transfusion	14%	18%	18%
Recalls being given written information	22%	21%	48%
Recalls risks being explained	32%	34%	51%
Recalls alternatives discussed	6%	6%	8%

Involving the patient - surgery

The decision to transfuse

Were you involved in the decision to transfuse you?	National	
	%	n
Yes	47	349
To a certain degree	22	166
No	24	180
Cannot remember	6	47
Not stated	0.1	1

Were you given the opportunity to ask questions?	National	
	%	n
Yes	66	489
No	21	154
Cannot remember	12	90
Not stated	1	10

If yes, were they answered satisfactorily?	National	
	%	n
Yes	56	272
No	3	13
Cannot remember	6	30
Did not ask questions	34	166
Not stated	2	8

Understanding written information given - surgery

- There was a statement in the casenotes that written information was given to 146 (**16%**) patients, not documented for 743 (81%) and not stated for 27 (3%)
- Patient recall of being given written information, and if they understood it

Were you given written information?	National	
	%	N
Yes	21	156
No	69	511
Cannot remember	10	71
Not stated	1	5

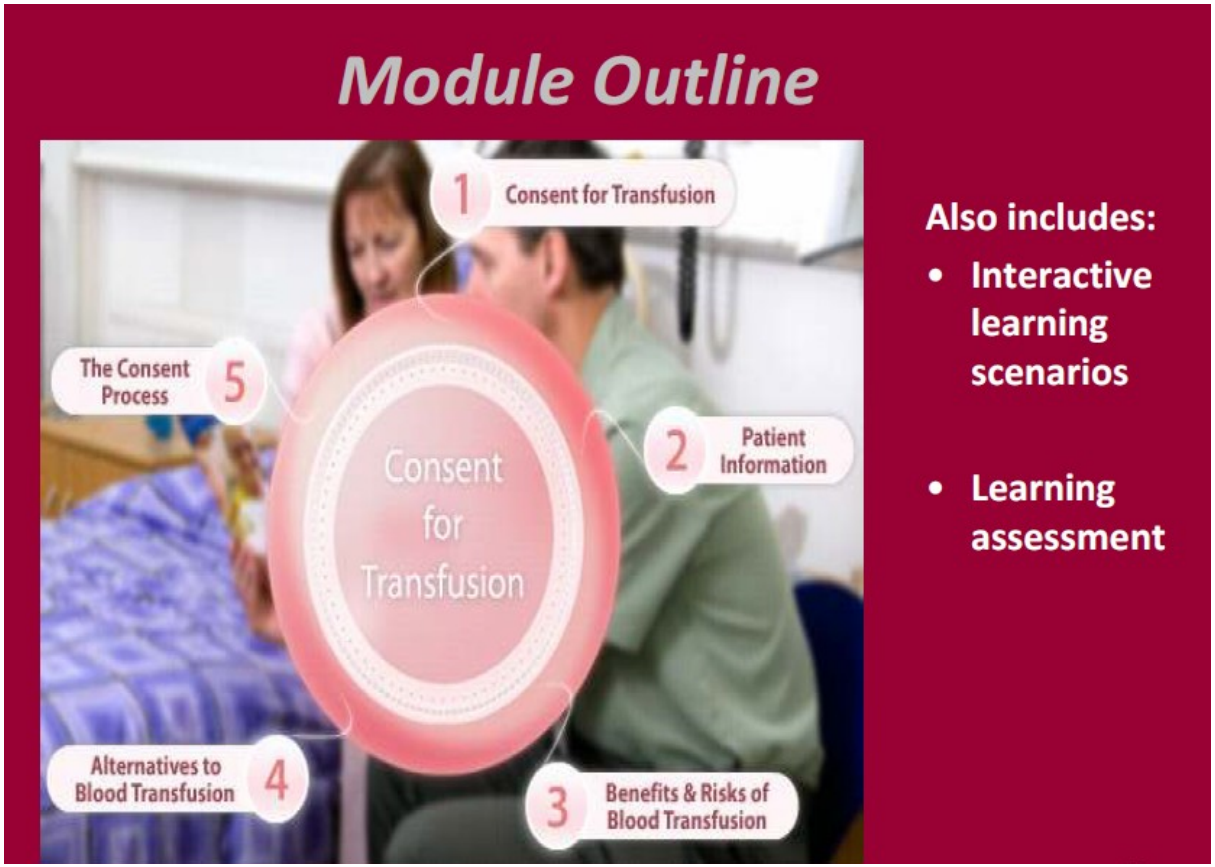
If yes, did you understand that information?	National	
	%	N
Yes	92	144
No	4	7
Not stated	3	5

Staff Survey (n=1663) – data for all specialities

- 85% of staff said they explained the rationale to the patient
- 65% stated they had documented this
- 25% said they discussed side effects or complications
- 38% said they discussed alternatives or advised there were none

elearning module

- The uptake of the eLearning module on patient consent and transfusion is low
- Only 38% of medical and 24% of nursing respondents reported using this



Conclusions

- A difficult and challenging audit to conduct – but extent of participation despite challenges is gratifying

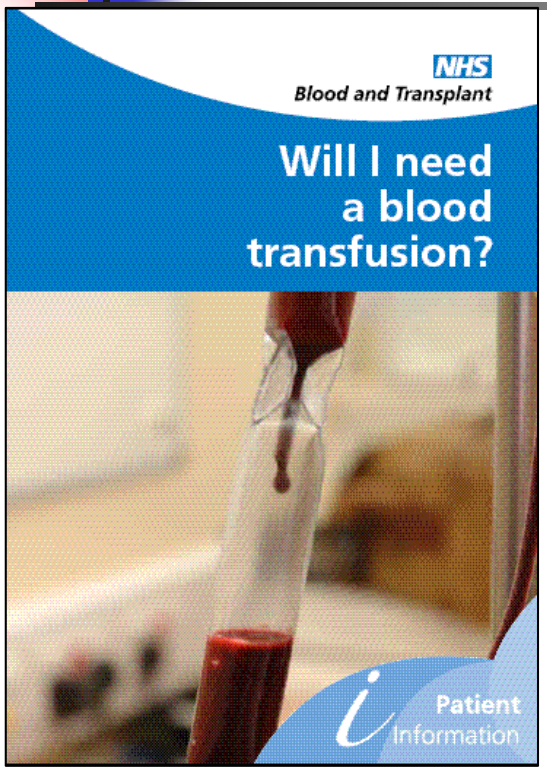
- This is the largest audit ever undertaken of consent/information in adult patients in the UK

- Many limitations eg
  - Did not include those transfused in an emergency
  - Only included adult patients
  - For practical reasons we could not offer the survey in non-English languages, which limited the possible respondents

Key findings and suggested actions

- Policies within Trusts state need for patient information and consent but practice needs to be improved with emphasis on documentation
  - Incorporation into pre-op pathways
  - Provision of information leaflets with first unit of blood
- Junior doctors in particular are involved in prescribing blood
  - urgent need to strengthen their training on patient consent and appropriate prescribing
  - This is also in keeping with SHOT recommendations highlighting junior doctor errors
  - Promote greater use of elearning module

Provision of written patient Information – Time for change?



www.blood.co.uk

- The audit showed lack of provision of written information to patients in all specialties on transfusion
- Summary of findings- all patients
- case note audit (19% documented as receiving these)
- patient feedback (28% recalled receiving these)
- staff feedback (18% of staff provided these)
- demonstrating a major discordance with written policies within Trusts.

Key findings and suggested actions

- Development and dissemination of patient leaflets needs review
  - need to explore innovative methods to provide information to patients including use of information technology

Patient information and consent for transfusion is an essential component of Patient Blood Management

Time for Action!

The Project Group

- Jan Robinson – Patient representative
- Dr. Shubha Allard – Barts Health NHS Trust and NHSBT (chair)
- Marie Browett – University Hospitals Leicester
- Dr. Helen Busby – Independent Adviser
- Miss Emma Court – General Surgical Registrar
- Anne Davidson – PBM Practitioner, NHSBT
- Douglas Watson – Scottish National Blood Transfusion Service
- The National Comparative Audit team - John Grant Casey, Derek Lowe

Acknowledgements

- Our thanks to all participating hospitals

- The Australian and New Zealand Society of Blood Transfusion for sharing their audit templates