

Effective Consent for Obstetric Procedures: A quantitative review of consent stickers

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Objectives

Written consent is required for all caesarean sections and operative deliveries however the process of consent is not standardised and can often be time-consuming. The use of consent stickers offers the opportunity for uniformity in the consent process by providing clear clinical documentation of all associated risks of the intervention. This project aims to introduce consent stickers into Obstetrics at North Middlesex University Hospital and improve the process of consent.

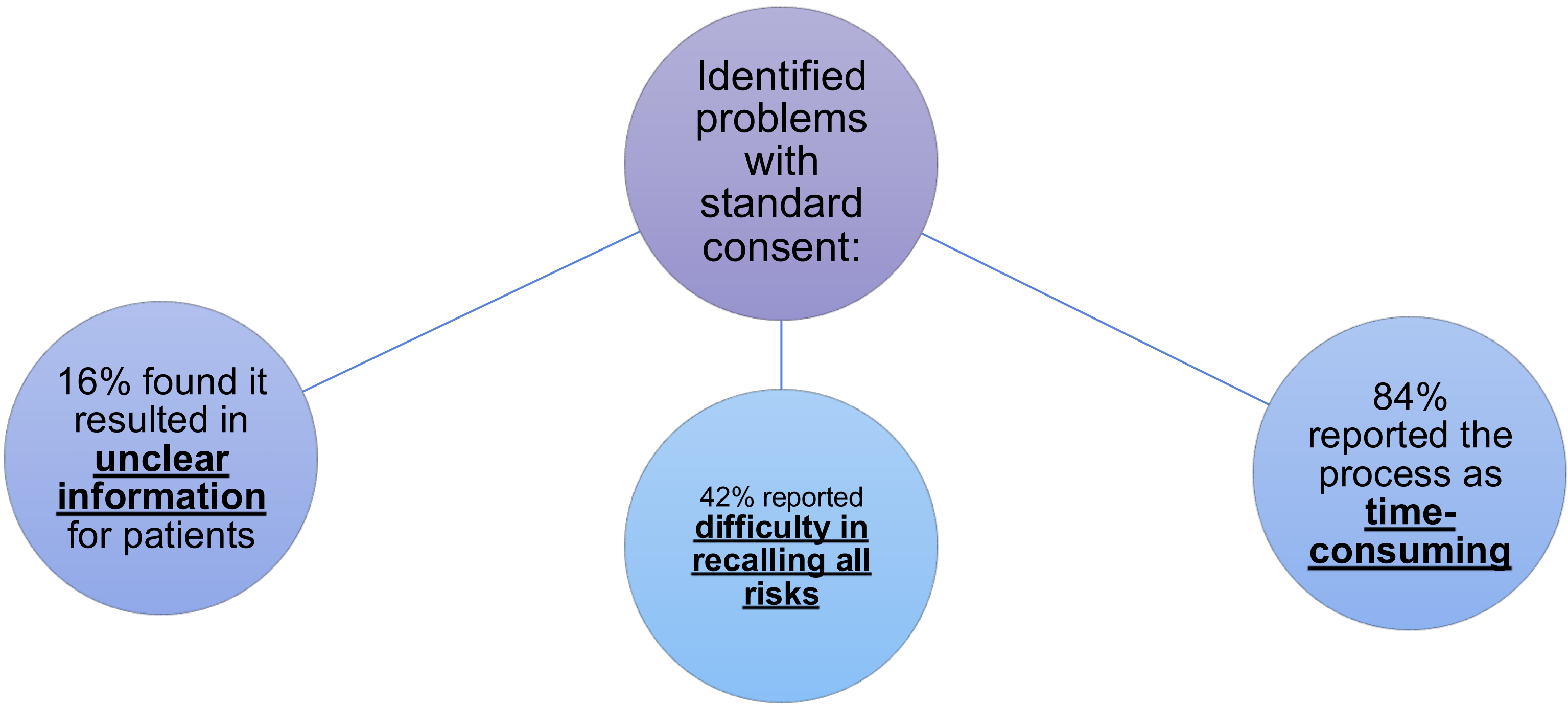
Design

Quantitative study using staff and patient surveys to analyse effectiveness of consent stickers.

Method

Consent stickers were produced for both caesarean sections and trial of operative delivery +/- caesarean section containing associated risks and prevalence rates as per RCOG guidelines. Online pre and post surveys were created for staff to understand the advantages and disadvantages of the process. Written surveys were also used to capture the patient experience of consent stickers.

The surveys received a total number of 47 responses. A range of SHOs, registrars and consultants completed the pre-survey to understand opinions on standard written consent. The majority of these clinicians reported carrying out consent at least weekly. The pre-survey identified some of the problems with manual consenting including:

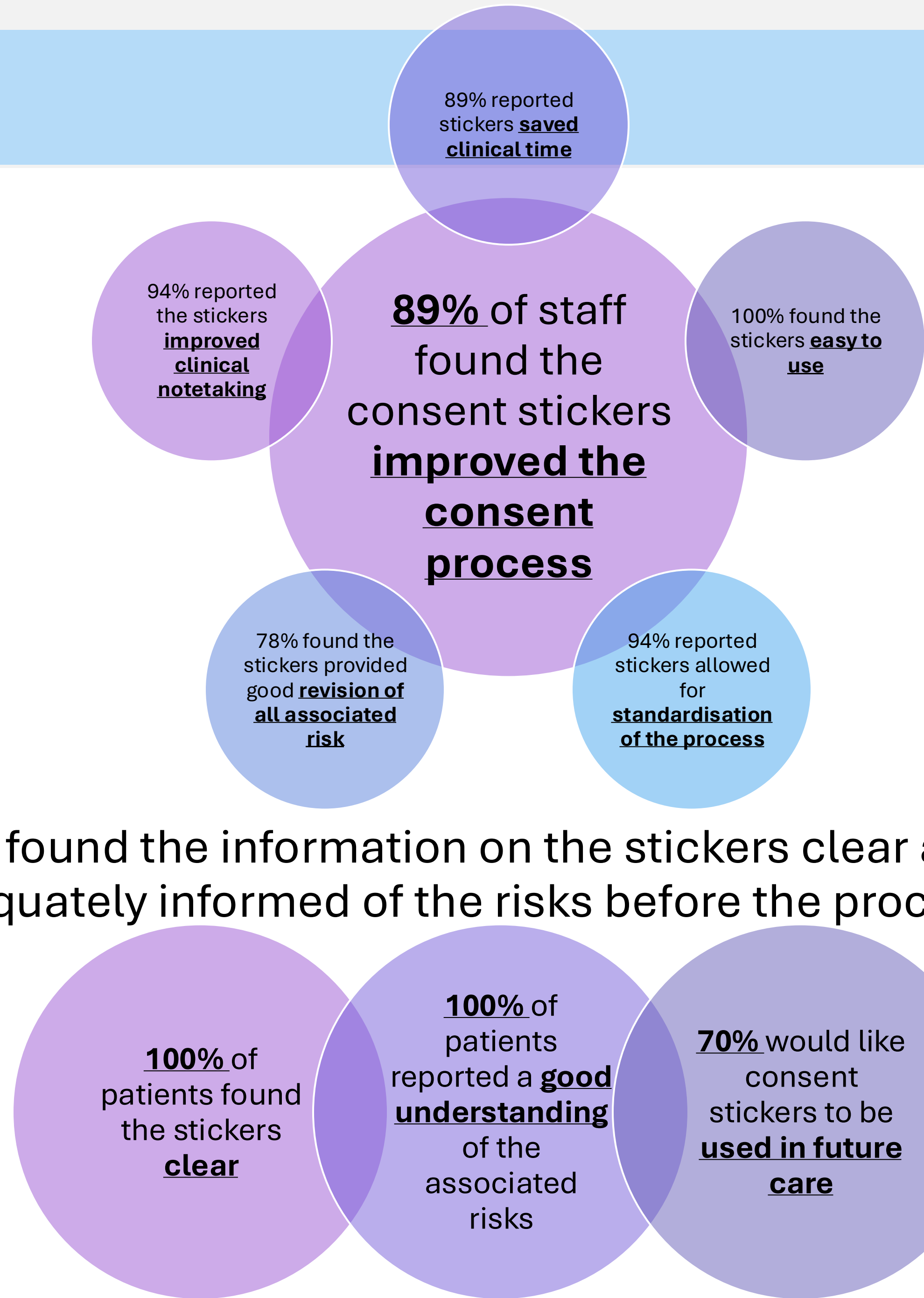


Following the introduction of consent stickers across the Obstetric department. Staff then completed a post-survey to rate their experience of the process.

PROCEDURE	CAESAREAN SECTION DELIVERY OF THE BABY(IES) THROUGH A CUT IN THE ABDOMEN (TUMMY)
INTENDED BENEFITS	To deliver the baby(ies) through a cut in the abdomen (tummy)
FREQUENT RISKS	Maternal: wound/abdominal discomfort (few months) (9:100), heavy bleeding (5:1000), Infections (6:1000), Readmission to Hospital (5:100). Fetal: Lacerations (cuts) (1-2:100)
SERIOUS RISKS	Emergency hysterectomy (7-8:1000), Need for further surgery at a later date (5:1000), Admission to ITU (9:1000), Clots in legs or lungs (4-16:10000), Bladder injury (1:1000), Ureteric injury (3:10000), Stillbirth in future pregnancies (1-4:1000), Placenta covering the entrance to the womb in future pregnancy (4-8:1000), Increased risk of uterine rupture during subsequent pregnancies/deliveries (2-7:1000), Unable to drive for up to 6 weeks, Death (1:12000)
ADDITIONAL PROCEDURES	Repair to the bladder, bowel or major blood vessels, embolisation (temporary blockage) of vessels supplying uterus, Life-saving hysterectomy, blood transfusion.

PROCEDURE	TRIAL OF OPERATIVE VAGINAL DELIVERY +/- CAESAREAN SECTION USE A VACUUM CUP OR FORCEPS TO ASSIST DELIVERY OF THE BABY +/- CAESAREAN
INTENDED BENEFITS	Assist the delivery of the baby using a vacuum cup or forceps +/- caesarean section
FREQUENT RISKS	Maternal: Postpartum haemorrhage (1-4:10), Vulval & Vaginal tear (very common) Bladder/bowel dysfunction Fetal: Marks/lacerations (very common), Bleeding above skull bone (1-12:100), Jaundice (5-15:100), Retinal haemorrhage (17-38:100) Maternal: Wound/abdominal discomfort (few months) (9:100), Heavy bleeding (5:1000), Infection (6:1000), Readmission to hospital (5:100) Fetal: Lacerations (cuts) (1-2:100), Difficulty in delivery (1:4) breathing difficulty (1-8)
SERIOUS RISKS	Maternal: 3rd/4th degree perineal tear (Vacuum 1-4:100, Forceps 8-12:100) Clots in legs or lungs (4-16:10000), Injury to bladder (1:1000) or Ureters (3:10000), Death (1:12 000) Risks in future pregnancy: Stillbirth (1-4:1000), Placenta covering womb opening (4-8:1000), Uterine rupture (2-7:1000) Fetal: Bleeding under the scalp (3-6:1.000), Bleeding in the brain (5-15:10.000) Facial nerve palsy (rare)
ADDITIONAL PROCEDURES	Episiotomy (Vacuum 5-6:100, Forceps 9:10), Manoeuvres for shoulder dystocia, Repair to bladder, bowel or major blood vessel, Embolisation (temporary blockage) of vessels supplying uterus, Life-saving hysterectomy, Blood Transfusion

Results



All of the patients found the information on the stickers clear and felt that they were adequately informed of the risks before the procedure.

Conclusions

Overall, the introduction of consent stickers at North Middlesex University Hospital was successful as staff believe it improved the consent process by saving time and creating a standardised approach. They were also well received by patients.

Future work should involve expanding the use of the consent stickers across a variety of Obstetric and Gynaecological procedures to further optimise both the consent process and patient experience. The consent stickers at North Middlesex Hospital will continue to be used within the department and they may be used when developing digital consent in the future. This will allow for standardised consent across a range of languages resulting in a more accessible consent experience.