Clinical Issues
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Continuing Education Contact Hours
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Purpose/Goal
To educate perioperative nurses about providing safe nursing care throughout the perioperative continuum.

Objectives
1. Discuss practices that could jeopardize safety in the perioperative area.
2. Discuss common areas of concern that relate to perioperative best practices.
3. Describe implementation of evidence-based practice in relation to perioperative nursing care.

Accreditation
AORN is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

Approvals
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Informed consent for repeated procedures

**QUESTION:**
We often have patients who come to the OR multiple times for repeated procedures (eg, bronchial washings, debridement of wounds or burns). Some of these patients do not have the capacity to sign an informed consent, and we must find the person holding medical power of attorney each time. Does AORN have guidelines regarding the need for a new consent each time a patient returns to the OR for the same procedure?

**ANSWER:**
AORN’s “Recommended practices for perioperative health care information management,” states, “the patient care record must include a complete and accurate informed patient consent for each surgical or invasive procedure to be performed.” There is no recommendation regarding the duration of consent. Informed consent is most commonly given per treatment/procedure; if the health care provider has knowledge that the treatment course will require several secondary or follow-up treatments, this may be discussed and documented along with ramifications in order for the patient or his or her representative to accept or reject the course prescribed. Health care organization policies should specify the criteria for consent, including the length of the proposed treatment period when repeated procedures are performed. In the case of repeated procedures or treatments, informed consent is an ongoing process that should provide an opportunity for periodic review of the patient’s understanding and confirmation of continued consent.

A new consent form should always be signed if the patient’s condition changes or other aspects surrounding the treatment or procedure have changed (eg, bronchoscopy with biopsy) since the original consent was given. The perioperative nurse’s role is to facilitate a new informed consent process if the preoperative assessment has determined a change in the patient’s condition or

Obtaining informed consent after administration of preoperative sedation

**Use of medical scribes in perioperative services**

Key words: informed consent, surgical consent, preoperative sedation.
there is a deviation in the treatment period or plan. Generally, consents for treatment should be valid for an individual procedure or a planned treatment course during a specified treatment period that has been discussed and agreed upon by the physician and the patient or his or her representative.2

In the past, obtaining informed consent was solely the responsibility of the physician. The Centers for Medicare & Medicaid Services regulations now require facilities to establish a process that ensures that the health care team evaluates the patient’s or his or her representative’s level of understanding regarding the patient’s health, diagnosis, and prognosis and the risks and benefits of the proposed procedure. This ensures that the patient or the legal representative is involved in planning care and is able to make an informed decision. The process also should include criteria for obtaining consent when the patient is not competent to give it or refuses treatment or when consent is needed for repeated procedures.4 The perioperative nurse can facilitate a policy review to ensure that facility policy meets the needs of this particular patient.

It is important to understand the differences between informed consent and obtaining signatures documenting that informed consent has taken place. Informed consent is more than just an administrative or legal task performed by the perioperative nurse to witness the patient’s signature. It is an opportunity to build a meaningful rapport and trusting relationship with the patient and the patient’s family members and serves as a means to validate the patient’s understanding of the planned procedure or treatment.5,6 Goals of an informed consent process include to

- improve outcomes,
- increase patient safety,
- protect patient autonomy,
- promote meaningful decision making, and
- reduce liability exposure.7

The informed consent process is an educational and communication process that is an ethical obligation and is required by regulatory statutes in all 50 states.8

The informed consent process involves the exchange of information between the patient and his or her professional caregivers. The physician is responsible for explaining in detail the patient’s diagnosis; the nature and purpose of the planned procedure or treatment; alternatives that may be available, including no treatment; and the benefits and risks of all options.8 An effective model of communication for obtaining informed consent is the “teach-back” method, in which the provider explains the principal message in clear and simple language and then asks the patient to rephrase the message based on his or her understanding.6,9 It is also the duty of the physician to evaluate the degree to which the patient understands the information presented, discuss any additional questions or assumptions the patient may have, and determine whether the patient has accepted the risks and is agreeing to the planned procedure.

The perioperative nurse’s role as the patient’s advocate means that the nurse is responsible for protecting the patient’s dignity, identifying and addressing any expressed fears, and determining the patient’s ability to understand what has been discussed and make an informed decision. The perioperative nurse should not provide additional information or answer questions pertaining to risks, benefits, or alternatives,3 but the nurse has a responsibility to report to the physician any doubts or concerns regarding the patient’s understanding or capacity to make decisions.10,11 Finally, the perioperative nurse may witness the patient’s legal signature on the consent form, which properly documents the

- name of the health care facility,
- specific procedure to be performed with indications listed,
- name of the surgeon,
- statements regarding the risks and benefits as explained by the provider,
- name and signature of the patient and witness, and
- date and time of the signatures.1

This action of witnessing the signing of the surgical consent also validates that the informed consent process has been completed.3

AORN
Obtaining informed consent after administration of preoperative sedation

**QUESTION:**
At our facility, the anesthesia care providers prefer to medicate patients in the preoperative holding area to decrease their anxiety. This practice causes controversy if the patient has not signed the informed consent before receiving this medication. Can the patient provide informed consent after sedation has been given?

**ANSWER:**
State or local agencies may regulate sedation considerations for the facility’s informed consent policy. Health care organizations’ informed consent policies generally require obtaining the consent signatures before medication administration.1,2 According to AORN’s “Recommended practices for perioperative health care information management,” the informed consent process must be documented, and a properly executed informed consent should be obtained unless the circumstance is designated as an emergency situation.3

Perioperative nurses should be aware of the health care organization’s policy for obtaining signatures for consent.

Collaboration and communication between the perioperative team members is essential to determine the sequence of key events in regard to medication administration and documentation of consent. If the policy states the consent signature should be obtained before medications are given, the nurse should be aware of actions to take when the policy has not been followed. AORN’s “Recommended practices for perioperative health care information management” also states,

*A comprehensive patient-centric record of care reflects interactions between the patient’s health care team and those individuals legally representing or providing physical, spiritual, or other support services to the patient. Documentation of interactions provides the groundwork for transparency in care planning through effective representation of the patient’s involvement in the*
The perioperative nurse’s role as a patient safety advocate would include facilitating a discussion with the patient, surgeon, and anesthesia care provider to determine the patient’s cognitive capacity to sign consent forms after receiving a sedative medication and then documenting the interactions between the caregivers and the patient and the reason and rationale for the decision.\textsuperscript{4-6} The documentation of this exchange also provides a testament that the patient has been involved in his or her care and treatment.

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REFERENCES

RESOURCE

Use of medical scribes in perioperative services

QUESTION:
Is it acceptable to use medical scribes in the perioperative area?

ANSWER:
The practice of using scribes has existed for thousands of years and ended primarily when printing was invented in the early 15th century. Before the invention of the printing press, scribes copied books over and over again.\textsuperscript{1} Scribes have been used in emergency departments to enter physicians’ notes and follow up on prescriptions, laboratory tests, specialty consultations, and records from other hospitals since the early 1990s.\textsuperscript{2} This role is experiencing a resurgence with the advent of electronic health records (EHRs).\textsuperscript{1} With the implementation of EHRs, hospitals saw physicians’ productivity decrease by as much as 30% while they were learning to navigate and cope with the new technology.\textsuperscript{3} Physicians also reported that they were spending too much time on data entry or constantly looking at the computer screen and not the patient.\textsuperscript{4,5} Some hospitals and physicians believe that scribes are filling a necessary niche during the transition from paper to electronic records.\textsuperscript{4}

The primary function of medical scribes, or clinical information managers as they are sometimes called, is to create and maintain a patient’s medical record under the supervision of a physician.\textsuperscript{5,6} They are unlicensed health care workers and cannot act independently, but they can document the dictation or activities and interactions of the physician and patient into the EHR. They also may assist in gathering test results and other ancillary documentation to aid the physician in decision support; they may not give verbal orders or enter orders into the EHR.\textsuperscript{5,7} Several companies and training programs offer scribe services; however, there are no standardized backgrounds, prerequisites, or training protocols for scribes. The role is often performed by pre-med
students who have a desire to learn about patient care and work flow patterns.3,5

Scribes are employed in a variety of ways, depending on the practice setting; the scribe may accompany the physician and other health care providers into the examination room and transcribe the visit information into the EHR, listen and observe the encounter from an adjoining room to assist the physician with documentation or gathering test data, or participate in these activities via video and audio feeds from a virtual office. Some physicians believe that adding another person in the examination room may have a negative effect on the doctor-patient relationship or that the patient will feel uneasy.3-5 One approach is for the physician to interview and examine the patient, preserving the doctor-patient relationship and the comfort of the patient; the scribe then joins the visit to document the physician’s summary of the visit’s findings, including diagnosis; medication changes; and additional recommendations, testing, or appointments that may be required.3,6

Medical scribes are not currently being used in inpatient facilities or perioperative settings. If a perioperative department decides to employ scribes to assist with documentation, it is the responsibility of the perioperative nurse to understand the facility’s policy regarding the scribe’s role and the authentication process. AORN’s “Recommended practices for perioperative health care information management” states, “Perioperative nursing documentation should correspond to local, state, and national regulatory requirements.”8(p384) If scribes are used, policies should be in place to identify their

- job description,
- orientation and training,
- competency, and
- performance evaluations.

The Joint Commission requires hospitals and ambulatory surgery centers to maintain complete and accurate records in which certain elements are documented and properly authenticated.9 Policies should be in place to authenticate medical record scribe entries that are separate from physician record entry authentication.7 “Documentation entries made into the patient health care record must include an authentication process at the completion of the documentation process or according to the organization’s established policies.”8(p385) AORN

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References
1. Conn J. Getting it in writing. Docs using scribes to ease the transition to EHRs. Mod Healthc. 2010;40(6):30, 32.
2. Meyer H. The doctor (and his scribe) will see you now. Hosp Health Netw. 2010;84(12):41-42. 44.

The author of this column has no declared affiliation that could be perceived as posing a potential conflict of interest in the publication of this article.
LEARNER EVALUATION

CONTINUING EDUCATION PROGRAM

Clinical Issues

This evaluation is used to determine the extent to which this continuing education program met your learning needs. The evaluation is printed here for your convenience. To receive continuing education credit, you must complete the Learner Evaluation online at http://www.aorn.org/CE. Rate the items as described below.

PURPOSE/GOAL
To educate perioperative nurses about providing safe nursing care throughout the perioperative continuum.

OBJECTIVES
To what extent were the following objectives of this continuing education program achieved?

1. Discuss practices that could jeopardize safety in the perioperative area.
   Low 1. 2. 3. 4. 5. High

2. Discuss common areas of concern that relate to perioperative best practices.
   Low 1. 2. 3. 4. 5. High

3. Describe implementation of evidence-based practice in relation to perioperative nursing care.
   Low 1. 2. 3. 4. 5. High

CONTENT

4. To what extent did this article increase your knowledge of the subject matter?
   Low 1. 2. 3. 4. 5. High

5. To what extent were your individual objectives met?
   Low 1. 2. 3. 4. 5. High

6. Will you be able to use the information from this article in your work setting? 1. Yes 2. No

7. Will you change your practice as a result of reading this article? (If yes, answer question #7A. If no, answer question #7B.)
   7A. How will you change your practice? (Select all that apply)
   1. I will provide education to my team regarding why change is needed.
   2. I will work with management to change/implement a policy and procedure.
   3. I will plan an informational meeting with physicians to seek their input and acceptance of the need for change.
   4. I will implement change and evaluate the effect of the change at regular intervals until the change is incorporated as best practice.
   5. Other: _______________________________

   7B. If you will not change your practice as a result of reading this article, why? (Select all that apply)
   1. The content of the article is not relevant to my practice.
   2. I do not have enough time to teach others about the purpose of the needed change.
   3. I do not have management support to make a change.
   4. Other: _______________________________

8. Our accrediting body requires that we verify the time you needed to complete the 1.0 continuing education contact hour (60-minute) program: _______________________________