Healthcare in hospitals is increasingly delivered by multidisciplinary teams and this can present communication challenges for consultants.

Junior staff

As a consultant, it is likely that you will be required to supervise and train junior medical staff. It is common for junior doctors and students to accompany consultants in clinics, on ward rounds and in theatre as part of their training. You should bear in mind the requirement to obtain informed consent from patients to disclose identifiable confidential information (including the results of investigations, such as x-rays) for teaching purposes, and prior to any examination or intervention conducted for training purposes.

During ward rounds, junior doctors are often asked to record your decisions in your capacity as the consultant.

While it would seem unreasonable for you to check each and every entry your junior doctors make, it is your responsibility to ensure their accuracy. You should ensure that junior doctors keeping notes on your ward rounds fully understand what has been discussed and decided for each patient and the importance of ensuring that the notes accurately reflect this.

Referral, delegation and transfer of patient care

The management of patients in hospital usually involves a wide range of clinical teams. Patients may need to be referred to other teams or services.

The GMC says in paragraph 44 of Good Medical Practice (2013) that doctors ‘must contribute to the safe transfer of patients between healthcare providers and between health and social care providers’. This means that, when referring or transferring a patient to the care of another specialist or provider, you should provide all relevant information about the patient and check, where practical, that a named clinician or team has taken over responsibility when your role in providing a patient’s care has ended.

During ward rounds, junior doctors are often asked to record your decisions in your capacity as the consultant.

Sometimes it is appropriate to delegate by asking a colleague or junior member of the team to undertake a particular aspect of care or treatment on your behalf. Paragraph 45 of Good Medical Practice (2013) states that, when you delegate, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care.

Handover and cover when you are off duty

Effective handover is essential. You should ensure that appropriate handover arrangements are in place for your patients. Adequate time should be set aside to hand over the care of your patients to your colleagues. Try not to allow the pressures of clinical work to encroach upon this aspect of communication, which is essential to patient safety.

When you are off duty you should be satisfied that suitable arrangements have been made for your patients to be cared for by colleagues with the appropriate qualification, skills and experience to provide safe care for the patient.

To highlight the importance of proper care handover, the National Patient Safety Agency (NPSA)¹ and the Junior Doctors Committee of the BMA produced a best practice guide: Safe Handover; Safe Patients: guidance on clinical handover for clinicians and managers.

Footnote

¹ On 1 June 2012 the key functions and expertise for patient safety developed by the National Patient Safety Agency (NPSA) transferred to the NHS Commissioning Board Special Health Authority.
The guidance identifies common problems which occur during handover. For example, the failing to make roles and responsibilities clear, which can lead to different members of the team assuming that one of their colleagues has updated the team taking over when in fact this has not happened. It states that every hospital needs to develop its own handover policy and provides examples of successful schemes from hospitals around the country.

The advice given to ensure safe handover includes the following points.

- Involve all key members of the multidisciplinary team. Each trust should identify the key people who need to attend handover meetings. The ideal model includes all grades of staff from each included specialty, sub-speciality or ward as appropriate.

- Be aware of any new locums on the team and make sure suitable arrangements are in place to familiarise them with local systems and hospital layout.

- Ensure handover is at a fixed time, of a sufficient length, and in a room that is large enough for all to attend and be suitably free from distractions.

- Ideally handovers should be ‘bleep free’, except for immediately life threatening emergencies.

- Make all staff aware of the handover period and arrange shifts for all staff involved so that they can attend in working time.

- Ensure handovers are supervised by the most senior clinician present and have clear leadership. Avoid too much jargon and explain any abbreviations.

Information which might be included in written handover includes current in-patients, accepted and referred patients due to be assessed, accurate location of all patients and operational matters relevant to clinical care, such as ITU bed availability. Discuss patients with potential problems so management plans can be clarified to ensure appropriate review. It is also worth discussing other outstanding tasks and when they should be completed.

We run interactive courses on effective colleague communication skills. For more information please visit themdu.com/learn

---

Questions and answers

**Q** It’s my usual practice to ask the junior doctors to obtain pre-operative consent from patients admitted for elective surgical procedures. However, the most recent F1s have suggested that they consider this delegation may be inappropriate. What should I do?

**A** A junior doctor with limited or no experience of the procedure to be undertaken may lack adequate understanding of the nature of the operation, including the possible risks and complications, to explain the procedure in appropriate detail to the patient. We advise consultants to follow the GMC’s guidance in Good Medical Practice (2013), paragraph 45, which states that the delegating doctor must be satisfied that the person to whom the task is delegated has the necessary qualifications, skills and experience to provide the care or treatment.

The GMC’s guidance Consent: Patients and doctors making decisions together (2008) elaborates on this and indicates that it is the responsibility of the doctor undertaking the investigation or providing the treatment to discuss it with the patient (paragraph 26).

The guidance adds that the task may be delegated, provided the person to whom you delegate has the necessary training and experience, complies with the GMC guidance and has sufficient knowledge of the investigation or treatment that is proposed, as well as an understanding of the risks involved.

The delegating doctor will remain responsible for ensuring that the patient has been given sufficient time and information to make an informed decision.

The delegating doctor also has a duty to ensure that the patient has given their consent before the investigation or treatment begins (paragraph 27).

Some F1 doctors, particularly at the start of their rotations, may not have the necessary knowledge and experience to perform the task of obtaining consent. You may therefore consider it appropriate to complete the process of consent yourself or at least ensure that it is delegated to another sufficiently experienced junior member of your team.

This example is fictional but based on cases from the MDU’s files.