Medico-legal risk and your practice

Checklist for General Practitioners

Understanding your risk is a process of identifying, analysing and evaluating medico-legal risks in your practice.

Managing your risk is a process of selecting the most advantageous method of reducing your exposure to medico-legal risk.

The following checklist will assist you to:
- Assess the medico-legal risk in your practice
- Identify preventable and predictable medico-legal risks
- Develop practical and accessible strategies to minimise your medico-legal risk
- Reduce exposure to litigation and complaints.

This checklist is a starting point that aims to help you identify areas in your practice where you may like assistance. Please note that it does not represent benchmarks for best practice and it does not purport to be fully inclusive or to provide any legal or medical advice.

As a member of Avant you and your staff are entitled to access the Medico-Legal Risk Advisory Service for advice on developing strategies to reduce your exposure to the risk of litigation or complaints.

For more information contact Avant’s Medico-Legal Risk Advisory Service on 1800 128 268 or e-mail riskadvisory@avant.org.au
1. Communication with patients

☐ Patients are familiarised with practice policies, including fees and billing arrangements
☐ Difficult communication with patients is identified and addressed
☐ Interruptions are minimised during consultations
☐ Bad news is delivered to patients with care and sensitivity
☐ The boundaries of the therapeutic relationship are recognised

2. Patient expectations and patient selection

☐ Patients know what to expect from their treatment
☐ Unrealistic expectations are identified and resolved
☐ Patients who are demanding, hostile, do not take your advice or are disinterested in discussion of treatment are managed appropriately

3. Communication with colleagues and staff

☐ Roles and responsibilities are clarified with colleagues and staff in relation to continuing patient care
☐ You work collaboratively with other members of the healthcare team
☐ You are available for consultation with junior staff under supervision
☐ Practice staff have clear roles and responsibilities
☐ Staff understand about safety, privacy and confidentiality

4. Diagnosis and treatment

☐ Past entries in the notes are reviewed
☐ Past and current medical conditions are taken into consideration
☐ Explanation is given about the need to disrobe, specific instructions are given about what clothing needs to be removed and draping provided
☐ A chaperone is offered for any intimate examination
☐ Colleagues are consulted when you are unsure about patient management, and a second opinion is offered if appropriate
☐ The need to refer a patient to another doctor is recognised
☐ Social history is considered when determining treatment plan
☐ Patients understand the treatment plan
☐ Treatment is reviewed over time for effectiveness
☐ Medications are reviewed over time for effectiveness and potential harm
☐ A multi-disciplinary approach is taken to managing complex problems

5. Consent and disclosure of risks

☐ Risks of procedures or treatments are discussed with patients
☐ Risks discussed may include general risks, procedure—or treatment—specific risks, and risks that are of concern to or are specific to the individual patient
☐ Where there are significant risks or the patient shows concern about the risks, the consent discussion is reflected in the notes
☐ Patients indicate understanding of their treatment options, and provide feedback on their level of understanding
☐ Estimated costs are discussed prior to a procedure or treatment
☐ Interpreter service is available for patients who do not speak English

6. Patient referral and follow up

☐ Urgent appointments with specialists are made by the doctor or receptionist and the details are recorded in the patient’s file
☐ Referral letters contain relevant history and clinical details
☐ A patient follow-up system is in place to monitor compliance or attendance for review
☐ Attempts to contact or follow up the patient are documented in the patient’s file
☐ Other attending practitioners are kept informed of patient care issues

7. Diagnostic test tracking

☐ System in place for tracking specimens/tests
☐ The doctor reviews, and signs and dates or electronically verifies every result
☐ System in place for actioning abnormal results

8. Medical records

☐ Compliance with Commonwealth and State-based regulations and policies governing medical records
☐ Data security is maintained
☐ If computerised, data is backed up regularly. The back-up is kept off-site, is tamper-proof and can be restored
☐ Records are legible and contain the following information:
  • What the patient tells you about their condition and concerns
  • Objective examination, diagnosis and management plan
  • Discussion of risks and complications of a proposed procedure
  • Details of telephone discussion(s) with patient or colleagues
  • Copies of results and operation reports
  • Copies of referral letters to and from other practitioners
  • Degree of urgency in referral letters
  • Details of post-operative visit and examination
  • Current health summary

9. Medication storage and prescribing

☐ Controlled substances are stored and prescribed in accordance with State regulations
Each patient’s file contains a medication summary
- Patients are assessed before prescriptions are prepared
- Patients are provided with information about any medication prescribed, including risks and alternatives
- Consent is obtained when prescribing new medication
- There is a system for monitoring patients who have been prescribed addictive medications or those with serious side effects, including dosage, frequency and authorities
- Any samples provided to patients are documented
- Repeat prescriptions are not provided without seeing the patient
- State and Territory legislation is complied with in regard to prescription of addictive or off-label use of medication

10. Confidentiality and Privacy
- The practice complies with Privacy legislation and has a written policy
- Practice staff understand when patient information can be released and to whom
- Patient details cannot be overheard or viewed by patients in the waiting room
- Medical records, appointment book and computer screens are away from public view
- All staff sign a confidentiality agreement

11. Telephone enquiries
- Protocol in place regarding what and when information can be disclosed over the telephone
- Telephone calls recorded in book/carbonised pad/electronically
- System in place to ensure phone calls are returned

12. Appointment systems
- The doctor determines action for cancellations and ‘did not attends’
- A permanent record kept of cancellations and ‘did not attends’
- There is a practice ‘triage’ system
- Provision is made for urgent consultations
- A backup/restore system is used for computerised appointments.

13. Policy and procedure manual
- Contains current policies and procedures
- Staff are familiar with the content of the manual

14. Staff orientation and training
- Orientation program for new staff
- Job descriptions are signed by staff and employer
- Clear delineation of roles and level of authority
- Training is available to reflect the needs of their position, including how to deal with patients requesting urgent attention

15. Managing adverse events
- Steps are taken to minimise the likelihood of adverse events
- The practice has a protocol for recording and dealing with adverse events and near misses
- The underlying cause of an adverse outcome is identified
- Adverse events are responded to in a timely manner
- Avant is notified of incidents that may give rise to a claim and/or a complaint

16. Complaints handling
To a complaints body:
- Avant is notified of all complaints to your registration board or complaints body
- Advice is sought from Avant before responding to such complaints

Direct patient complaints:
- There is a written policy in your practice for dealing with complaints, with which staff are familiar
- Complaints are responded to in a timely manner
- There is a willingness to resolve grievances and complaints
- Staff have designated roles and appropriate training in dealing with complaints
- The practice encourages feedback from patients
- The practice has a procedure for review of complaints
- Avant is notified of serious complaints

17. Advertising, websites and publications
- Products and services are advertised in accordance with the relevant legislation (Medical Practice Regulations, the Fair Trading Act, Trade Practices Act, Therapeutic Goods Act)
- Photographs represent realistic results. They are de-identified and used with patient permission
- Promotional material is accurate and realistic and includes sufficient information about the risks and limitations of the procedure
- Promotional material is not misleading and does not raise unrealistic patient expectations
- Website users are clearly informed that information on the site is not a substitute for professional medical advice
- Website content is regularly reviewed, updated and complies with relevant legislation
FOR PROCEDURALISTS

18. Fees for service
- Information is provided to patients about any additional fees such as theatre, pathology, anaesthetics

19. Operative care
- All equipment is checked prior to use
- You are familiar with the theatre environment and team
- If relevant in your state or territory of practice the mandatory “Time out” policy is observed before commencing a procedure
- You personally clarify the operative site and supervise patient positioning
- You comply with the process for reporting incidents and adverse outcomes at facilities you attend
- You know the policies and procedures specific to the facilities you attend
- Junior staff are adequately supervised

20. Post-operative care
- A written protocol is followed for managing patients in the post-operative period
- Discussion is held with patients regarding what they may expect in the post-operative period, including when and how to contact you
- Written instructions are provided to the patient on discharge, including what they should do to aid recovery
- Surgeon and anaesthetist (if necessary) are available to review patients, or responsibility is clearly delegated to an appropriate person
- Arrangements are in place to review patients prior to discharge
- Patients are sufficiently recovered from procedures and sedation prior to discharge
- A plan has been made for managing patients who have travelled a long way or are from out of town
- A report is provided to other treating or referring doctors on the outcome of surgery

OBSTETRICS

21. Antenatal care
- Patient expectations of labour and delivery are established early in the antenatal period
- Discussion and explanation of all tests and monitoring is undertaken, including the associated risks
- A thorough medical history and health assessment is recorded
- Discussion is held regarding practitioner availability for delivery and alternative arrangements
- Disclosure is made on arrangements for shared care and how this affects the patient

22. Labour and delivery
- There is a written protocol for hospital staff on management of patients who present in labour, including when and how you would like to be notified of admission
- CTG tracing is faxed to you if unable to attend immediately when notified of a problem
- Patients administered oxytocins are monitored closely
- Where labour is not going according to plan, discussion with patients regarding a change in the specific mode of delivery is documented, including your advice e.g. conversion to LSCS for trial of scar
- When reviewing patient in labour documentation includes:
  - Time, dilation, effacement, station
  - Any variations in foetal monitoring
  - Time of viewing CTG tracing
  - Any discrepancies between your findings and those in the nursing record
- Your own account of delivery is documented and includes:
  - Appearance of liquor
  - If assisted delivery, type of assistance
  - If shoulder dystocia, manoeuvres performed
  - Loops in cord

23. Postnatal care
- Written protocol for postnatal care
- Patient given written contact details if they have concerns
- Appointment for postnatal check made on discharge
- Patient information provided on postnatal depression, feeding problems, settling in at home etc.

ANAESTHETICS

- Relevant history about medications, past experience with anaesthetics and medical conditions is obtained
- Roles and responsibilities are clarified in relation to patient care
- Colleagues are consulted when you are unsure about patient management
- Patients informed about anaesthesia and options discussed for sedation and pain relief
- Information provided to referring surgeons for patients, where feasible
- Equipment checked prior to commencement of procedure
- Patients under sedation are appropriately monitored
- Accurate recording of anaesthetic management
- You are available for post-anaesthetic review

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