Medico-legal risk and your practice

Checklist for PGY1 and PGY2

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
Risk Assessment Checklist

1. Partnerships with patients/communication
   - Difficulties in communicating with patients are identified and managed
   - A mutual understanding about a procedure, treatment or care plan is established between the patient, doctor and other staff
   - Awareness of the importance of communication within the multi-disciplinary team
   - Interruptions are minimised during consultations
   - Bad news is delivered to patients with care, sensitivity and privacy

2. Patient expectations/ patient selection
   - Patients’ suitability to undergo a procedure is assessed
   - Patients know what to expect from their treatment, including rate of recovery and likely outcome
   - Unrealistic expectations are identified and clarified
   - Patients who are demanding, hostile, disinterested in discussion of treatment are identified and managed appropriately

3. Communication with colleagues, staff and supervisor
   - Roles and responsibilities are clarified in relation to continuing patient care
   - Work collaboratively with other members of the health care team
   - Ensure VMO is made aware of new admissions and/or changes in a patient’s condition or orders.
   - Understand about safety, privacy and confidentiality

4. Diagnosis and treatment
   - Take account of social history when determining treatment plan
   - Take account of past and current medical conditions
   - Review past entries in notes
   - Ensure you are aware of tests that have been ordered and that results are in patient notes
   - Patients understand the treatment plan
   - Patients know what to expect from their treatment
   - Review treatment and medications over time for effectiveness and potential harm
   - Consult with colleagues or superiors when unsure about patient management
   - Second opinion offered if you or the patient has any doubts regarding diagnosis or treatment
   - Recognise when to refer a patient to another doctor
   - Take a multi-disciplinary approach to managing complex problems

5. Consent and disclosure of risks
   - Encourage patients to attend with a family member, partner when discussing proposed procedures and consent
   - General and specific procedural risks are discussed
   - Risks of a procedure or treatment that are material to the patient are identified and recorded
   - Consider and discuss the consequences to the patient if complications do occur, such as conversion to an open procedure or longer hospital stay and recovery
   - Tools such as diagrams and brochures are used to facilitate discussion
   - Patients’ suitability to undergo a procedure is assessed
   - Difficulties with the consent process are managed, for example:
     - Treatment of children
     - The process of gaining consent when the patient is incapable
     - When there is dispute over patient management
     - When a patient refuses treatment
     - When a patient demands treatment that is inappropriate
   - Alternatives to surgery are discussed
   - Patients provide feedback on their level of understanding
   - The treating doctor takes responsibility for the consent process
   - Consent discussions are reflected in the notes or letter to the referring doctor
   - Estimated costs are discussed prior to a procedure, including likely additional costs associated with procedures
   - Keep a record of discussion about estimated costs

6. Intra-operative care
   - All equipment checked prior to use
   - Familiarity with theatre environment and team
   - Access to senior staff if experiencing difficulty
   - Understanding of facility-specific policies and procedures
   - Personally clarify the operative site and supervise patient positioning
   - If in NSW, remember the mandatory Time out policy before commencing a procedure
   - Familiar with process for reporting incidents and adverse outcomes to relevant facilities
   - Understanding of facility specific Policies and Procedures

7. Post-operative care
   - Familiarity with protocol for managing patients in the postoperative period
   - Discuss with patients what they may expect in the postoperative period
- Written instructions are provided to the patient on discharge, including what they should do to aid recovery
- Patients know how to recognise complications and how to contact you
- 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
- Report back to other treating or referring doctors

8. Diagnostic test tracking
- System in place for tracking specimens/tests sent and received for the patient
- The doctor reviews, signs and dates every result
- System in place for actioning abnormal results

9. Patient referral and follow up
- Urgent appointments are made by the doctor or delegated to another staff member, and the details are recorded in the patient’s file
- Ensure the patient is made aware of the reasons for a referral and the importance of follow-up
- Ensure referral letters contain relevant history and clinical details
- A patient follow-up system is in place to monitor and review compliance or attendance for review
- Attempts to contact or follow up the patient are documented in the patient’s file
- Report back to referring doctor

10. Medical records
- Awareness of 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 and tamper-proof
- Records are legible and contain the following information
  - What the patient tells you about their concerns and condition
  - 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 (e.g. pathology, x-ray)
  - Copies of referral letters to and from other practitioners
  - Degree of urgency in referral letters to and from other practitioners
  - Details of post-operative visit and examination

11. Managing adverse events
- Steps are taken to minimise the likelihood of adverse events
- Awareness of and compliance with protocols and policy directives for recording and dealing with adverse events and near misses
- The underlying cause of an adverse outcome is identified
- The practitioner responds to the adverse event in a timely manner
- Avant is notified of incidents

12. Complaints handling

To a complaints body:
- Avant is notified of all complaints to your registration board or complaints body
- Do not respond to such complaints directly: seek advice from Avant

Direct patient complaints:
- You are familiar with the policy for dealing with complaints
- Timely response to complaints
- Willingness to resolve grievances and complaints. Avant is notified of complaints

13. Prescribing medication
- Each patient’s file contains a medication summary
- There is a system for monitoring patients who have been prescribed addictive medications including dosage, frequency and authorities
- Patients are provided with detailed information about any medication prescribed

14. Confidentiality and Privacy
- The practitioner is familiar with Privacy legislation
- Patient details cannot be overheard by other patients
- Medical records are kept away from public view

15. Telephone enquiries
- Understanding what and when information can be disclosed over the telephone
- Ensure phone calls are returned
- All significant phone conversations are documented in the patient’s file
16. Looking after yourself

- You understand that caring for others means you must care for yourself.
- You maintain a balanced lifestyle with exercise and a social life.
- You have your own GP.
- You recognise when you are becoming distressed from overwork or difficulties at work, and know how to seek help or support.
- You ensure you de-brief after a difficult encounter: doctors are human too and need support, care and reassurance.
- You seek advice on dealing with ‘absent’ or hostile supervisors.