Medico-legal risk and your practice

Checklist for Paediatricians

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. Communication with patients and their parents (or guardian)
   - Patients’ parents are familiarised with practice policies, including fees and billing arrangements
   - Reasons for parents’ anxiety are explored and taken into account in your clinical reasoning
   - Difficult communication with patients or their parents is identified and addressed
   - Interruptions are minimised during consultations
   - Bad news is delivered to patients and their parents with care and sensitivity

2. Patient expectations and patient selection
   - Parents and, if of sufficient maturity, patients know what to expect from their treatment
   - Unrealistic expectations are identified and resolved
   - Parents 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 have good relationships with the obstetricians with whom you work (if you have neonatal patients)
   - Nursing staff discuss patient management issues with you
   - You are available for consultation with junior staff under supervision
   - You are accessible to referring GPs and are diligent in returning their phone calls
   - 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 account
   - Parents and patients are encouraged to talk about their concerns
   - Parents’ instincts about their child’s condition are given fair consideration
   - Explanation is given about the need to disrobe, specific instructions are given about what clothing needs to be removed and draping provided
   - Parents are encouraged to act as chaperone for any intimate examination, with the patient’s permission
   - Colleagues are consulted when you are unsure about patient management, and a second opinion is offered if appropriate

5. Consent and disclosure of risks
   - General and specific procedural risks are discussed and recorded
   - Risks of procedure or treatment that are of concern to or are specific to the individual patient or parents are identified and recorded
   - Consent discussions are reflected in the notes and/or in the letter to the referring doctor
   - Treatment options are discussed and documented
   - Tools such as diagrams and brochures are used to assist explanations to patients
   - Parents and, if appropriate, patients provide feedback on their level of understanding
   - Responsibility for the consent process is taken by the treating doctor
   - Estimated costs are discussed and documented prior to a procedure, including likely additional costs associated with procedures
   - Consent is obtained from the parents/guardian, or where the child/young person has sufficient maturity (possesses sufficient understanding and intelligence to enable full understanding of what is proposed), the patient.
   - 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’s parents 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 and parents tell 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 parents or colleagues
  - Copies of results
  - Copies of referral letters to and from other practitioners
  - Degree of urgency in referral letters
  - Details of post-operative visit and examination

9. Medication storage and dispensing
- Controlled substances are stored and prescribed in accordance with state regulations
- Each patient’s file contains a medication summary
- There is a system for monitoring patients who have been prescribed medications with serious side effects, including dosage, frequency and authorities
- Any samples provided to patients are documented
- Consent is obtained when prescribing new medication
- Parents are provided with information about any medication prescribed including risks and alternatives
- Patients are assessed before prescriptions are prepared
- 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
- Where the patient has sufficient maturity, the patient’s permission is sought to discuss confidential health information to third parties including the parent/guardian

11. Telephone enquiries
- Protocol in place on 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’
- 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 reflect what staff are expected to do in the practice
- 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
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 and parents
- 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)
- 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 theatre environment and team
- If relevant in your state or territory of practice the mandatory “Time out” policy is observed before commencing a procedure
- The operative site is clarified by you and patient positioning supervised by you

20. Post-operative care

- A written protocol is followed for managing patients in the post-operative period
- Discussion is held with patients and/or parents as appropriate regarding what they may expect in the post-operative period, including when and how to contact you
- Written instructions are provided to the parent 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 and parents are clear about who to contact for review or if they have concerns
- A report is provided to other treating or referring doctors on the outcome of surgery