Medico-legal risk and your practice

Checklist for Surgeons
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Understanding your risk is a process of identifying and managing areas of risk in your practice to ensure the best possible outcomes. This checklist identifies aspects of your practice that may be exposed to risk.

For further information:

- log into Avant Risk IQ; [avant.org.au/Risk/IQ](http://avant.org.au/Risk/IQ) where you will find extensive risk education resources; factsheets, handbooks, eLearning courses and webinars, or
- contact Avant’s Medico-legal Advisory Service (MLAS) on **1800 128 268** (24/7 in emergencies), or
- email the Risk Advisory Service team [riskadvisory@avant.org.au](mailto:riskadvisory@avant.org.au) for risk advice.
Checklist for Surgeons

1. Communication with patients
   - Patients are familiarised with practice policies, including fees and billing arrangements
   - Communication challenges during consultations are recognised and managed professionally
   - Patient problems are elicited early and addressed appropriately before concluding the consultation
   - Interruptions are minimised during consultations
   - Bad news is delivered to patients with care and sensitivity
   - The boundaries of the therapeutic relationship are recognised and preserved
   - Prior to undertaking any intimate examination, an explanation is provided and permission is sought from the patient, and where appropriate a chaperone is offered. The acceptance or refusal of a chaperone is documented in the medical record
   - When a patient is required to disrobe, specific instructions are given about what clothing needs to be removed and draping provided

2. Patient expectations and patient selection
   - A patient’s suitability to undergo a procedure is assessed
   - Patients are appropriately informed and know what to expect from their treatment, including post-operative pain, rate of recovery and likely outcome
   - Unrealistic expectations are identified and addressed before commencing treatment

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, which are documented, along with confidentiality agreements, performance expectations and grievance procedures
   - Theatre staff and junior staff discuss patient management issues with you

4. Diagnosis and treatment
   - Past entries in the notes are reviewed at every consultation
   - Past and current medical conditions and medications are taken into consideration
   - Colleagues are consulted when you are unsure about patient management and a second opinion is offered if appropriate
   - A multi-disciplinary approach is taken to managing complex problems

5. Consent and disclosure of risks
   - Ultimate responsibility for the consent process is taken by the treating doctor although may be delegated to another
   - Risks discussed include general risks, procedure - or treatment - specific risks, and risks that are of concern to or are specific to the individual patient
   - Open-ended questions are used to ascertain the patient’s understanding of treatment and risks
   - The capacity of the patient to comprehend the nature and effect of the treatment to which he/she is giving consent is assessed and if found to not be competent the legally appropriate substitute decision maker to obtain consent is identified
   - Tools such as diagrams, brochures, videos and computer simulations are used to assist explanations to patients
   - Post-operative expectations are discussed including period of recovery, time off work etc
   - The consequences to the patient if complications do occur, such as a longer hospital stay and recovery, are discussed
   - The attendance of family members/partner is welcomed when discussing proposed procedures and consent
   - Estimated costs are discussed and documented prior to a procedure, including likely additional costs associated with procedures
   - Professional interpreter services are available and utilised for patients who do not speak English

6. Operative care
   - The mandatory “Time out” policy and process is observed before commencing a procedure (sign in), during the procedure (time out) and on completion of the procedure (sign out)
   - You are familiar with the theatre environment and team
   - You personally supervises patient positioning
   - You comply with the process for reporting incidents and adverse outcomes at facilities you attend
   - Know the policies and procedures specific to the facilities you attend
   - Junior staff are adequately supervised
7. 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 or else are only discharged into the care of a responsible person
- A plan is in place 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

8. Diagnostic test tracking
- A system is in place for tracking specimens/tests
- The doctor reviews, and signs and dates or electronically verifies every result
- A system is in place for actioning abnormal results
- A system is in place which proactively tracks clinically significant patients and identifies patients who fail to attend for diagnostic testing or referred appointments, and outstanding/lost test results

9. Patient referral and follow up
- Urgent appointments are made by the doctor or receptionist and the details are recorded in the patient’s file
- Referral letters are always personalised and contain relevant history and clinical details, while avoiding inclusion of unnecessary details (such as irrelevant past history)
- A follow-up system is in place to monitor compliance or attendance for review
- All attempts to contact or follow up the patient by the doctor or staff are documented in the patient’s file
- Other attending practitioners are kept informed of patient care issues in a timely manner
- A system is in place which proactively tracks clinically significant patients and identifies patients who fail to attend for diagnostic testing or referred appointments, and outstanding/lost test results

10. Medical records
- Medical records comply with Commonwealth and State-based regulations and policies
- 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.
- Records are stored for the period stipulated by relevant legislation
- Redundant records are securely destroyed, with a log kept detailing the date of disposal

11. Managing adverse events
- Adverse events or near misses are responded to following the Australian Open Disclosure Framework, Australian Commission on Safety and Quality in Healthcare:
  - an apology or expression of regret, which should include the words ‘I am sorry’ or ‘we are sorry’
  - a factual explanation of what happened
  - an explanation of the steps being taken to manage the adverse event and prevent recurrence.
- Through a periodic and proactive risk assessment, steps are taken to identify vulnerabilities and minimise the likelihood of adverse events
- The practice/hospital has a protocol for recording and dealing with adverse events and near misses
- Where possible, the underlying cause of an adverse outcome is identified for system improvement
- Adverse events are responded to in a timely manner, prioritising the prevention of any further harm to patients
- Avant is notified of incidents that may give rise to a claim and/or a complaint
12. Complaints handling

Notifications received from a complaints body:
- Avant is notified of all complaints to your registration board or state-based complaints body
- Advice is sought from Avant before responding to such complaints

Direct patient complaints:
- The practice and/or surgeon encourages feedback from patients
- There is a written policy in your practice for dealing with complaints, with which staff are familiar
- There is a system in place to provide a timely response to complaints
- Staff have designated roles and appropriate training in dealing with complaints
- Advice is sought from Avant before responding to online complaints

Online anonymous complaints:
- The practice has a written policy for dealing with online complaints/adverse ratings
- Online complaints/adverse ratings are ignored or handled in a professional and resolution focussed manner
- Patients and staff are not encouraged to leave “positive” ratings on online forums/rating sites
- Advice is sought from Avant before responding to online complaints

13. Appointment systems

- A permanent record kept of cancellations and ‘did not attends’
- The doctor determines action for cancellations and ‘did not attends’
- Provision is made for urgent consultations
- A backup/restore system is used for computerised appointments

14. Telephone enquiries and electronic communication

- Protocols are in place on what and when information can be disclosed over the telephone
- Telephone calls received are permanently recorded in book/carbonised pad/electronically
- A system is in place to ensure phone calls are followed up and returned when appropriate
- Clinical advice given by phone, or received from other clinicians in relation to a patient’s care, should be documented in the patient’s clinical file
- Phone calls received by doctors when on call, and on mobile phones, are documented as close to contemporaneously as possible, in the appropriate clinical file
- Any fax machine is located securely, away from access by patients or non-staff
- Incoming faxes are monitored for clinical urgent matters, and a doctor has responsibility for managing and determining appropriate follow-up for any clinically significant matters received
- If email is used, patients are informed in relation to the limitations of control over privacy prior to using email to communicate sensitive health information
- If email is used, a protocol is in place to protect privacy and restrict access to sensitive information by other practice staff

15. Confidentiality and Privacy

- The practice complies with current privacy legislation and has a written policy which is available in soft and hard copy for patients to access.
- Practice staff are trained and understand the circumstances when patient information can be released and to whom
- Patient details cannot be overheard or viewed by other persons in the waiting room
- Medical records, appointment book and computer screens are protected and away from public view
- All staff have signed a confidentiality agreement as a condition of employment

16. Policy and procedure manual

- The practice has a comprehensive manual containing all current policies and procedures
- Staff are familiar with and receive ongoing training with respect to the content of the manual
17. Staff orientation and training

☐ There is an orientation program for new staff
☐ Job descriptions reflect what staff members are expected to do in the practice
☐ Job descriptions are signed by staff members and employer
☐ There is a clear delineation of roles and level of authority
☐ Training is available to staff to reflect the needs of their position
☐ There is a documented chain of authority and grievance policy for dealing with unsatisfactory staff performance or breaches

18. Medication storage and prescribing

☐ Each patient’s file contains a current medication summary, including over the counter agents
☐ Patients are examined before prescriptions are provided
☐ Patients are provided with information about any medication prescribed, including risks and alternatives
☐ There is a protocol for monitoring patients prescribed addictive medications or those with serious side effects, including dosage, frequency and authorities
☐ Any samples provided to patients are documented in the clinical file
☐ All samples provided are labelled as per legislative requirements
☐ Repeat prescriptions are not routinely provided without seeing the patient

19. Advertising, websites and publications

☐ Products and services are advertised in accordance with the relevant legislation (Health Practitioner Regulation National Law 2009, Therapeutic Goods Regulation 1990 and Australian Consumer Law 2010)
☐ Online advertising does not include offers or inducements
☐ Social media or website content does not include testimonials or reviews
☐ Any photographs used represent realistic results. They are de-identified and used with signed 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