

# Medico-legal risk and your practice

## Checklist for Physicians

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](mailto:riskadvisory@avant.org.au)



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Australia's Largest MDO

# Risk Assessment Checklist

## 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
- Patients' suitability to undergo a procedure is assessed
- 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 health care 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. 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 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
- Patients provide feedback on their level of understanding
- The attendance of family members/ partner is welcomed when discussing proposed procedures and consent
- 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
- Interpreter service is available for patients who do not speak English

## 5. 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

## 6. Patient referral and follow up

- Urgent appointments with other 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 any post-operative visit and examination

## 9. 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

## 10. 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

## 11. 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 examined 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

## 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. 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

## 14. 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

## 15. Policy and procedure manual

- Contains current policies and procedures
- Staff are familiar with the content of the manual

## 16. 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

## 17. Procedural 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
- 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

## 18. Post-procedural 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

## 19. Endoscopic procedures - open access

- Patients are appropriately selected and assessed
- The referring practitioner provides details of:
  - Relevant medical history
  - Medications
  - Presenting symptoms
- Essential information regarding the procedure, including risks, has been explained to the patient prior to the day of the procedure, allowing valid consent
- Protocols are followed for managing patients assessed as unsuitable on the day of presentation
- Arrangements are in place for patient follow up

## 20. Testing and managing coronary artery disease

- Adequate monitoring is provided during stress testing
- Patients are supervised by the practitioner
- Staff are able to identify and coordinate immediate emergency action if required
- Patients are reviewed after a procedure
- Bypass facilities are available (for patients undergoing angiogram/angioplasty)
- Post-procedural information is provided to the patient

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