

Self-Administered Liability Risk Assessment Tool

Practice Information Systems Backed by Policies and Procedures

This assessment tool is designed to heighten your awareness of potential liability exposures which may exist within your practice, as patient injury can result from inadequate systems or system failure. Each practice may have an area which would benefit from incorporating written policies and protocols. Please share this assessment tool with your staff.

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| 1. Patients are informed of specific health care needs that require a follow-up appointment. | Yes | No |
| 2. My office has a patient reminder system for follow-up of examinations or tests. | Yes | No |
| 3. To ensure continuity of care, a follow-up appointment with the office is scheduled for patients who will have a procedure or be hospitalized. | Yes | No |
| 4. A log is available to record each specimen which is sent for analysis. | Yes | No |
| 5. The above log is used to confirm that each test result is received at the practice. | Yes | No |
| 6. A system is in place to record all ordered diagnostic tests. | Yes | No |
| 7. A system is in place to identify patients who are referred for a consult. | Yes | No |
| 8. An established procedure is followed to notify patients of all test results. | Yes | No |
| 9. My office has a written protocol to ensure that patients are informed of abnormal test results, and the information is documented. | Yes | No |
| 10. All procedures performed in the office are done by qualified staff. | Yes | No |
| 11. Office medical equipment is routinely inspected and serviced. | Yes | No |
| 12. A member of my staff is present during a patient exam when appropriate. | Yes | No |
| 13. My office follows a legally recommended procedure for termination of the physician/patient relationship. | Yes | No |

Please turn to the following pages for tips on procedural and policy practices.

Practice Information System, Protocol, Procedural and Policy Tips
to Promote the Physician-Patient Relationship

An office practice requires administrative systems and sound structure to support good, consistent patient care and effective risk management. Consider developing written descriptions of information management systems. Develop and maintain a policy and procedure manual to reflect current office procedures, policies and protocols. The manual should be reviewed annually, and updated as necessary.

1. All necessary follow-up should be communicated to a patient and promptly scheduled. Each patient encounter should end with a follow-up plan. Whenever possible, appointments should be scheduled for the patients prior to leaving the office. Consider implementing a mechanism (tracking system) such as a “tickler file” for sending reminder cards or calling a patient who should return for follow-up. The physician’s appointment schedule should be available to the staff for up to four months to one year in advance to promote scheduling of patient appointments, and diminish the possibility for lack of follow-up. Physicians often ask about their responsibility for patients who do not return for a recommended visit. Failure or delay in diagnosis is a common allegation which is difficult to defend when the physician cannot demonstrate that a “reasonable effort” was made to provide follow-up care. Therefore, all such efforts, whether or not successful, should be documented in the patient’s medical record.
2. Develop and utilize a patient reminder system (recall file) for tests and procedures ordered by the physician. A recall file alerts you to patients who have not followed through with your treatment plan. It is in the physician’s interest to contact the patient and express concern for the need to comply with the treatment /diagnostic plan or to meet and discuss these concerns.
3. As a means to promote continuity of care, consider implementing a policy to appoint patients for a follow-up office visit at the same time a surgical procedure or a hospitalization is scheduled. Patients who are discharged on weekends may not receive or understand instructions regarding the need for a timely follow-up appointment, and as a result, follow-up may be delayed.
4. The physician ordering a test bears the responsibility for that test and test result. A policy should describe a system (log) to record each specimen that is sent for analysis. Logs of pending test results can be used to check (✓) off test reports when they are received. You may use the same log to indicate that the test results were reviewed by a health care provider. All test reports should be initialed prior to being placed in a patient’s medical record.
5. A method should be in place to ensure that each test result is received by the office, and that the test result is seen in a timely fashion by the physician. The system will alert you that a test result is absent or pending, enabling you to follow-up with the lab. It may also indicate that the patient did not comply with the treatment plan. You cannot rely on patients calling if they have not heard from you. A log of pending test results that is checked off when results are received, and checked off again when they are reviewed, with an indication that results are reported to the patient, will reduce the chance for results being misplaced.
6. A process (system) should identify all ordered tests and alert your office when a patient fails to keep an appointment for a diagnostic test. It is the responsibility of your office to initiate contact with these patients. A fail-safe follow-up system should be in place when a patient is referred for diagnostic testing. Patients who understand the nature and importance of an exam are more likely to participate in the exam. Again, your follow-up measures should be reflected in the patient’s record.

7. A process should be in place to alert the office that a patient has not completed a recommended referral. In addition, a systemic method to determine whether or not consultants' reports are received and reviewed will avoid breakdowns in the continuity of care and the communication among multiple care providers.
8. The practice should have an effective and professional protocol for notifying patients of test results. Establish a written policy and uniform procedure to notify patients of test results. Documentation of notification should occur on the report along with documentation of any follow-up instructions.
9. The physician ordering the test bears the responsibility for communicating test results to patients, and should develop a mechanism to do so. Physicians sometimes require that the patient call for results or will call the patient only when results are adverse. Such procedures often leave patients unaware of the meaning of tests or the need for follow-up care, and also increase the risk of positive findings not being communicated to the patient. Consider whether each entity the physician deals with has a protocol (back-up system) for follow-up on all abnormal findings. When positive findings exist, all referrals to other physicians or entities should be tracked and followed-up when necessary. Accurately record in the medical record all decisions, impressions, conversations, test results and recommendations.
10. A process should be used to document the skill level and staff education surrounding medical equipment usage in the office. Education and training of equipment users includes the recognition of product hazards and the proper operation of the equipment or use of the product.
11. Physicians should carefully select medical office equipment, use the equipment in a manner intended by the manufacturer and maintain and service the equipment. All equipment should be maintained according to the manufacturer's specifications and guidelines. Maintain all warranty books and user-instructions in a dedicated file where employees can access them. If equipment is involved in a patient injury, it may be necessary to preserve the equipment for possible product liability. If this situation arises, do not return the equipment to the manufacturer.
12. Consider implementing a system to routinely ask patients whether or not they prefer to have a chaperone with them during an examination or a procedure. Document the patient's response in the medical record. Having a female staff member present when examining female patients provides a feeling of comfort for the patient and the physician and avoids the risk of allegations of inappropriate conduct by the physician.
13. At times, a physician may feel it necessary to terminate treatment of a patient and withdraw from the physician-patient relationship. The physician is obligated to protect patient care and to minimize any allegations of abandonment. He/she is obligated to give due notice to the patient and provide the patient a grace period to secure the services of another medical attendant. A written policy should address this situation. Notification, whether or not a personal conversation has taken place, should be sent by certified mail, return receipt requested. Consider referring the patient to 2 or 3 practitioners who can provide the care required, or refer the patient to a local hospital which may have a list of physicians accepting patients. Provide the patient with ample time to make a transition, and offer to make a copy of the chart available with the appropriate authorization to the new physician. Carefully document the chart to reflect your course of action.



PLEASE NOTE: *These self assessments are educational only, intended to suggest steps that health care practitioners may take in connection with their ongoing efforts to promote patient safety and prevent medical injury. These recommendations are, however, subject to the professional judgment of the physician and other qualified professional personnel, who have the ultimate authority and responsibility in all matters of patient care. Medical Mutual Insurance Company of Maine does not warrant or represent that the practices it recommends reflect the prevailing standard of care, or that they will be found to comply with federal, state or local laws, regulations or other legal requirements.*