DOCTORS' PRACTICE RISK SELF-ASSESSMENT

This questionnaire is intended to assist you in assessing potential risk exposures in your rooms. Many of the questions reflect optimal practice goals that can enhance the management of risk and the "defensibility" of complaints or claims that may arise.

Instructions

- Optimally, the self-assessment should be completed together by all specialists in your practice in conjunction with the Practice Manager.
- Critical questions are highlighted in grey.

Committee of Presidents of Medical Colleges

HRRI
Healthcare Risk Resources International

The SSRS is a joint initiative of the Australian Government Department of Health and Ageing and the Committee of Presidents of Medical Colleges

DEMOGRAPHICS

1. Type of practice:

☐ solo ☐ group

If group:

a) ☐ Single specialty
☐ Multispecialty

size:

b) ☐ 1-2 doctors ☐ 3-4 doctors ☐ >5 doctors

2. Does your practice include:

a) Training Fellows? ------------ ☐ yes ☐ no

b) Registered Nurses? --------- ☐ yes ☐ no

c) Other? Please define ---

Please indicate your response to the questions by circling the appropriate number.

PRACTICE COVERAGE

		always	sometimes	rarely	never	N/A
3.	Your practice has 24 hour coverage.	4	3	2	1	0
4.	You use an answering service.	4	3	2	1	0
5.	Voice mail or answering machines are used to respond to incoming calls if the office is unattended.	4	3	2	1	0
6.	On-call coverage is provided by a doctor of the same specialty.	4	3	2	1	0
7.	Covering doctors have access to your patients' medical records.	4	3	2	1	0

8. You use a specific locum service, well known to you and your practice.	4	3	2	1	0
9. You are aware of the qualifications and competencies of the doctors employed by the locum service(s) you use.	4	3	2	1	0
10. You receive a written report from the locum service following a contact with one of your patients.	4	3	2	1	0
11. Covering doctors are informed of your patients with anticipated problems.	4	3	2	1	0
12. When you provide coverage for other doctors, you have access to their patients' medical records.	4	3	2	1	0

Comments: --

CONFIDENTIALITY OF PATIENT INFORMATION

	always	sometimes	rarely	never	N/A
13. Open-faced postcards are sent to patients to remind them of appointments or inform them of results.	4	3	2	1	0
14. Patient medical records are maintained in a confidential location protected from public access.	4	3	2	1	0
15. Patient medical records are retained in accordance with local or state legislation.	4	3	2	1	0
16. Information from patient medical records is released only after a written authorisation has been obtained.	4	3	2	1	0

	always	sometimes	rarely	never	N/A
17. You review requested records prior to their release.	4	3	2	1	0
18. Original records are released in circumstances other than a court order.	4	3	2	1	0
19. You send confidential medical information via FAX.	4	3	2	1	0

Comments: --

DOCUMENTATION

	always	sometimes	rarely	never	N/A
20. Each patient's medical record contains:					
▪ a standardised patient information questionnaire	4	3	2	1	0
▪ an updated problem list	4	3	2	1	0
▪ a history and physical examination	4	3	2	1	0
▪ allergies documented in a clearly visible and consistent location	4	3	2	1	0
▪ current medication list documented in a consistent location	4	3	2	1	0
▪ documentation of all instructions (written and/or verbal) given to patient	4	3	2	1	0
▪ documentation of patient wishes related to resuscitation.	4	3	2	1	0

	always	sometimes	rarely	never	N/A
21. Entries in the patient's medical record are:					
▪ labeled with the patient's identification	4	3	2	1	0
▪ dated and timed	4	3	2	1	0
▪ signed/initialed by the caregiver	4	3	2	1	0
22. The patient's medical record documentation for each encounter contains:					
▪ reason for the visit	4	3	2	1	0
▪ history and physical examination consistent with the reason for the visit	4	3	2	1	0
▪ review of any test results or consultation reports	4	3	2	1	0
▪ working diagnosis consistent with the findings	4	3	2	1	0
▪ treatment plan consistent with the diagnosis	4	3	2	1	0
▪ follow-up plan	4	3	2	1	0
23. If you use an electronic medical record, provision is made for regular backup and storage of tapes.	4	3	2	1	0
24. Diagnostic imaging tests contain a written interpretation.	4	3	2	1	0
25. Is there a policy for giving written instructions to patients, which include responsibility for recording this in the patient record?	4	3	2	1	0

Comments: --

INFORMED CONSENT

	always	sometimes	Rarely	never	N/A
26. The patients medical record contains documented evidence of shared decision-making between you and the patient.	4	3	2	1	0
27. A note is documented in the patient medical record when a patient refuses a recommendation for treatment.	4	3	2	1	0
28. You obtain written consent for all invasive procedures.	4	3	2	1	0
29. The consent includes warnings about driving, operating heavy machinery and signing/ witnessing documents.	4	3	2	1	0

Comments: ---

CLINICAL DATA

	always	sometimes	rarely	never	N/A
30. Your office system can determine whether patients' test results, and/or scheduled for tests, or consultations have been completed.	4	3	2	1	0
31. Consultation reports are dated and initialed by you prior to filing.	4	3	2	1	0
32. Normal test results are communicated to the patient.	4	3	2	1	0
33. You directly communicate abnormal test results to the patient.	4	3	2	1	0

	always	sometimes	rarely	never	N/A
34. Your office’s processes ensure that test results are communicated to the patient when he or she cannot be contacted by telephone.	4	3	2	1	0

Comments: --

TEACHING AND AUDIT ISSUES

	always	sometimes	rarely	never	N/A
35. Do GP registrars or medical students and other professional staff train in the practice?	4	3	2	1	0
36. Is each student / trainee evaluated annually?	4	3	2	1	0
37. Is this evaluation documented?	4	3	2	1	0
38. Is there a system for clinical audit in place in the practice?	4	3	2	1	0
39. Does the audit program include multi-disciplinary audits?	4	3	2	1	0

	always	sometimes	rarely	never	N/A
40. Is the audit process part of a wider program to monitor the quality of patient care?	4	3	2	1	0
▪ Does this program include: the collection and review of statistical data?	4	3	2	1	0
▪ Does it include: the use of generic screens or other indicators for the identification of specific cases for review?	4	3	2	1	0
▪ Does it include: patient record review (multi-disciplinary)?	4	3	2	1	0
▪ Does the program involve review of clinical incidents reported within the practice?	4	3	2	1	0
41. Is there a system of appraisal covering all practice staff?	4	3	2	1	0
42. Are training and development needs identified and incorporated in to staff training plans?	4	3	2	1	0
43. Is there a regular audit of patient records?	4	3	2	1	0
a) Does the audit cover patient condition?	4	3	2	1	0
b) Does the audit cover legibility?	4	3	2	1	0
c) Does the audit cover completeness?	4	3	2	1	0
d) Does the audit cover signature?	4	3	2	1	0

PROCEDURES PERFORMED IN ROOMS

		always	sometimes	rarely	never	N/A
44.	Invasive procedures requiring use of IV sedation are performed in your rooms.	4	3	2	1	0
45.	If used, regional anaesthesia is performed by a doctor.	4	3	2	1	0
46.	A trained staff member is dedicated to monitoring the patient when providing IV sedation.	4	3	2	1	0
47.	Pulse oximetry is used when sedation/analgesia is administered in your rooms.	4	3	2	1	0
48.	Patients who received IV sedation in your rooms **are allowed** to drive themselves home.	4	3	2	1	0
49.	Follow-up telephone calls are made to patients within 24 hours of a procedure requiring IV sedation or regional anaesthesia in your rooms.	4	3	2	1	0

Comments: ---

RECOVERY

		always	sometimes	rarely	never	N/A
50.	Patients are cared for post-procedure according to established policies/guidelines.	4	3	2	1	0

Comments: ---

EQUIPMENT

		always	sometimes	rarely	never	N/A
51.	Reusable equipment is processed according to Australian Standard AS 4187	4	3	2	1	0
52.	Single-use items are treated as such.	4	3	2	1	0
53.	Biomedical checks are routinely performed on monitoring equipment, defibrillator or all other medical equipment.	4	3	2	1	0
54.	Electrical equipment undergoes an electrical safety check annually.	4	3	2	1	0
55.	Records of these checks are documented and retained.	4	3	2	1	0
56.	You have an equipment register.	4	3	2	1	0

Comments: ---

EMERGENCY PREPARATION

		always	sometimes	rarely	never	N/A
57.	Your rooms have a plan to manage medical emergencies.	4	3	2	1	0
58.	Your capacity to manage medical emergencies matches the acuity of services provided in your rooms.	4	3	2	1	0
59.	If you have emergency resuscitation equipment in the rooms, there are staff available who are trained in the use of this equipment.	4	3	2	1	0
60.	You have a transfer mechanism to transfer unstable patients to an acute care setting.	4	3	2	1	0

Comments: --

MEDICATION MANAGEMENT

	always	sometimes	rarely	never	N/A
61. Patients receive instructions on potential drug reactions and medication use for all prescribed drugs.	4	3	2	1	0
62. Stored controlled substances are counted regularly and logged into a register in compliance with State legislation.	4	3	2	1	0

Comments: --

TELEPHONE COMMUNICATION

	always	sometimes	rarely	never	N/A
63. Telephone contacts, including after hour encounters with patients, are documented in the patient medical record.	4	3	2	1	0
64. Patient telephone contact documentation includes:					
▪ purpose of call	4	3	2	1	0
▪ advice given	4	3	2	1	0
▪ follow-up instructions	4	3	2	1	0
▪ name of personnel in contact with patient	4	3	2	1	0
▪ date and time of contact	4	3	2	1	0
65. Non-clinical staff do not respond to patient calls involving clinical problems.	4	3	2	1	0

	always	sometimes	rarely	never	N/A
66. If practice staff are allowed to respond to clinically-related telephone calls, they follow written protocols designed to direct their response.	4	3	2	1	0

Comments: --

PATIENT COMMUNICATION AND SATISFACTION

	always	sometimes	rarely	never	N/A
67. An information package describing your practice is provided to patients.	4	3	2	1	0
68. A staff member is present in the exam room when the examination door is closed.	4	3	2	1	0
69. Patients receive written copies of instructions given.	4	3	2	1	0
70. A survey is used to obtain information on patient satisfaction.	4	3	2	1	0
71. When a patient complains about a clinical case, you personally follow up with the patient.	4	3	2	1	0

Comments: --

BILLING AND COLLECTION

	always	sometimes	rarely	never	N/A
72. Medical records and billing history is reviewed by the doctor prior to initiating collection procedures.	4	3	2	1	0

Comments: --

APPOINTMENT/SCHEDULING/ACCESS TO CARE

73. What is the usual time period between a referral for a new patient and their first appointment?	**weeks:** <1	1-2	Over 2-4	Over 4
74. Once the patient comes for their appointment, what is the usual wait from scheduled appointment time to seeing you?	**minutes:** <15	15-30	31-45	>45
75. How much time do you schedule for an initial consultation?	**minutes:** <10	10-20	21-30	>30

	always	sometimes	rarely	never	N/A
76. Your appointment schedule allows sufficient time to see patients with urgent problems within the same day.	4	3	2	1	0
77. When a patient waits for an extended period, you apologise directly to the patient for the delay.	4	3	2	1	0
78. When a patient misses an appointment, will a phone call or letter occur for follow up?	4	3	2	1	0
79. Routine visits last at least 15 minutes.	4	3	2	1	0

	always	sometimes	rarely	never	N/A
80. Initial and yearly visits last longer than routine visits.	4	3	2	1	0

Comments: --

ROOMS MANAGEMENT

	always	sometimes	rarely	never	N/A
81. Your staff are aware of how their attitude, appearance and actions affect perceptions of the quality of care provided.	4	3	2	1	0
82. Nurses or other clinical staff (not doctors) practise within their legal scope of responsibilities (eg. Nurses Act).	4	3	2	1	0
83. The rooms' manual contains written policies and procedures pertinent to your office staff.	4	3	2	1	0
84. Your staff follow policies and procedures as outlined in the manual.	4	3	2	1	0
85. Employees receive written feedback at least annually on their performance compared to responsibilities outlined in their job description.	4	3	2	1	0
86. Universal precautions are used for personal protection by staff.	4	3	2	1	0
87. Used sharps (needles, knife blades, etc) are stored in puncture proof containers in compliance with state legislation.	4	3	2	1	0

		always	sometimes	rarely	never	N/A
88.	Medical or hazardous wastes are disposed of separately from general waste in compliance with state legislation.	4	3	2	1	0
89.	Regular quality control and preventive maintenance measures are in place for medical equipment used in the rooms.	4	3	2	1	0
90.	A log book is maintained for maintenance of equipment.	4	3	2	1	0
91.	You have a clear privacy statement available for all patients.	4	3	2	1	0
92.	Please rate your satisfaction with the following elements of your office setting:					
	▪ physical accessibility for disabled	4	3	2	1	0
	▪ physical appearance	4	3	2	1	0
	▪ adequacy of waiting room space	4	3	2	1	0
	▪ adequacy of examination room space	4	3	2	1	0
	▪ privacy of examination/ treatment areas	4	3	2	1	0
	▪ adequacy of parking space for patients	4	3	2	1	0
	▪ preventative health information leaflets	4	3	2	1	0
	▪ preventative health information leaflets in multiple languages	4	3	2	1	0

Comments: ---

This self-assessment was completed by:

Name: ____

Title: ____________________________ Date: __________________