

Checklist

PATIENT SAFETY & RISK SOLUTIONS

Risk Management Considerations in Orthopedic Practice

Orthopedic providers encounter various risks in day-to-day practice. Medical errors, adverse outcomes, and near-misses can result from issues related to technical skill, clinical judgment, communication, documentation, clinical systems, and more. The following checklist provides high-level considerations for reducing these risks and improving patient safety in orthopedic practice.

	Yes	No
Communication		
Do you provide patients with pertinent information, such as practice policies, patient rights and responsibilities, medication refill policies, work-related restrictions, etc.?		
Do you actively listen to patients without interrupting and repeat information to clarify meaning and reinforce understanding?		
Do you use layman's terms when talking to patients about procedures, treatment plans, anticipated benefits, potential risks, and alternative therapies?		
Do you adhere to a comprehensive informed consent process that includes verbal and written patient education?		
Do you provide patients with education materials that are written in plain language and include explanations of medical terms and visual aids to support comprehension?		
Do you use a technique such as teach-back to ensure patients understand informed consent discussions and their proposed treatment plans?		

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	Yes	No
Communication (continued)		
Do you use interpreting services and assistive technologies for patients who have communication barriers? ¹		
Are you using acceptable interpreting services, such as bilingual healthcare providers or staff members, staff trained as interpreters, onsite trained medical interpreters, or telephone or video medical interpreting services.		
Do you actively communicate and collaborate with the clinical teams providing patient care (e.g., primary care physicians, other specialists, etc.)?		
Diagnosis		
Do you perform a complete assessment for each patient, including establishing a differential diagnosis and considering appropriate diagnostic testing?		
Do you include the worst-case scenario as part of your differential diagnosis?		
Do you implement and utilize clinical pathways to standardize processes and support quality care?		
Have you considered using clinical decision support systems, diagnostic timeouts, consultations, and/or group decision-making to support clinical reasoning?		
Do you ensure timely ordering of tests and consults to prevent problems associated with ruling out or documenting abnormal findings?		
Do you review all diagnostic test results and consultative reports prior to filing them in patient records?		
Are high-risk patients systematically tracked to avoid failures in follow-up and diagnosis?		
Do you carefully consider repeated patient complaints or concerns when making clinical decisions about patient care and additional diagnostic testing?		

	Yes	No
Treatment/Surgery		
Do you conduct a thorough pre-procedure screening of patients for risk factors?		
Do you follow evidence-based guidelines specific to your specialty?		
Do you ensure that all appropriate health information for each patient is available prior to the start of a procedure?		
Are necessary equipment and supplies inventoried and verified prior to the start of a procedure?		
Are infection prevention and control best practices used to maintain the sterile field?		
Are patient safety precautions utilized during each procedure (e.g., proper positioning)?		
Do you and your surgical team participate in a timeout before each procedure?		
Does anesthesia monitoring occur throughout each procedure?		
Do you and your surgical team communicate about patient status throughout each procedure?		
Are strategies in place to minimize communication breakdowns and encourage team members to speak up about safety concerns?		
Are strategies in place to minimize noise and distractions in the operating room?		
Is a qualified healthcare provider immediately available during patients' recovery periods?		
Do you maintain a consistent postprocedure assessment process?		
Are patients appropriately monitored following procedures (e.g., vital signs, airway, mental status, pain, hydration, etc.)?		
Are patients evaluated against discharge criteria prior to discharge?		

	Yes	No
Treatment/Surgery (continued)		
Are patients and families/caregivers provided with appropriate education and instructions prior to discharge?		
Do patients receive a postdischarge follow-up call?		
Documentation		
Do you follow organizational timeframes for completing documentation?		
Does each patient's health record contain thorough and appropriate information, such as: History and physical? Current medications? Nonpharmacological interventions? Allergies? Pain assessments? Test results? Consults/referrals and related reports? Treatment goals? Preoperative screening results?		
Do you document the clinical decision-making process, treatment rationale, and follow-up plan?		
Do you document all phone calls and electronic communications related to clinical care?		
Do you document the informed consent process, including discussion of risks, benefits, and alternative treatment options?		
Are informed consent forms (if applicable) maintained as part of patient records?		

	Yes	No
Documentation (continued)		
Are required preoperative data documented and available at the time of surgery scheduling?		
Do you complete a detailed operative report the day of each procedure?		
Do you document all instances of patient nonadherence as they occur as well as any education provided to patients and families/caregivers regarding the consequences of not following the treatment regimen?		
Clinical Systems		
Does your organization systematically track diagnostic and consultative referrals from inception of the order until receipt and signoff of results?		
Does your organization have test-tracking safeguards in place to ensure:		
Tests are scheduled and completed?		
Test results are received?		
 Test results are reviewed by the ordering clinician? 		
 Patient are notified in established and appropriate timeframes? 		
 Test results are filed in patient records? 		
Decisions about care are documented?		
Are phone calls related to clinical care triaged by a clinician or through use of a written algorithm?		
Does your organization include review of clinical systems and administrative functions as part of quality improvement initiatives?		
Training and Performance Improvement		
Does your organization adhere to <u>credentialing</u> policies, including evaluation of procedural skills and competency with equipment?		
Do you participate in peer review activities to improve performance and quality?		

	Yes	No
Training and Performance Improvement (continued)		
Do you continue to enhance your technical surgical skills and communication skills through continuing education?		
Does your organization routinely evaluate quality indicators and implement performance improvement plans to reduce patient risks?		
Does your organization ensure that provider and staff member training is consistent with roles and responsibilities?		
Do providers and staff members in your organization receive appropriate training on new or upgraded systems and technologies?		

¹ Healthcare practices that receive federal financial assistance and/or funding are generally responsible for providing auxiliary aids or other service accommodations at no cost to the patient. Be cognizant of state and federal laws that apply to accommodating these patient communities.

This document does not constitute legal or medical advice and should not be construed as rules or establishing a standard of care. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

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