

Checklist

PATIENT SAFETY & RISK SOLUTIONS

Risk Management Considerations in Surgical Practice

Surgical providers face various risks in day-to-day practice. Medical errors, adverse outcomes, and near-miss events can result from issues related to technical skill, clinical judgment, communication, documentation, clinical systems, and more. The following checklist provides high-level considerations in several areas for reducing these risks and improving patient safety in surgical 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?		
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? (Note: A thorough informed consent and education process can influence patient satisfaction.)		
Are patient educational materials written in plain language?		
Do you ask patients to repeat, in their own words, their understanding of proposed treatment plans and informed consent discussions?		
Do you use interpreting services for patients who have language barriers?		
Do you actively communicate and collaborate with the clinical teams providing patient care (e.g., primary care physicians, other consultants, etc.)		

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	Yes	No
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 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?		
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?		

	Yes	No
Treatment/Surgery (continued)		
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?		
Is a qualified healthcare provider immediately available during each patient's recovery period?		
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?		
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 medical record contain thorough and appropriate information, such as history and physical, current medications, nonpharmalogical interventions, allergies, pain assessment, test results, consults/referrals, treatment goals, preoperative screening results, etc.?		
Do you document the clinical decision-making process, treatment rationale, and follow-up plan?		

	Yes	No
Documentation (continued)		
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?		
Is 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 noncompliance 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		
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	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 staff and provider training is consistent with roles and responsibilities?		
Do providers and staff in your organization receive appropriate training on new or upgraded systems and technologies?		

This document should not be construed as medical or legal advice. 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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