Managing Chiropractic risk

When it comes to protecting your livelihood, insurance is just one part of the big picture. There are a range of actions you can take to reduce the risk of a complaint leading to a claim against you. We're dedicated to keeping Australian chiropractors up to date with risk reduction strategies driven by real claims data.

That's why for this year's ACA Conference, we're giving you this bumper edition risk management booklet, tailored for chiropractors with actionable steps to help safeguard your practice. For more chiropractic risk articles and resources, visit **riskhq.com.au**.

Maintaining a safe chiropractic practice

All employers and employees have an obligation to create and maintain a safe working environment. And to do this we all need to think about what makes our workplace unique in terms of the risks to staff and the strategies needed to keep it safe.

There are a few ways in which chiropractic clinics can pose risks to the personal safety of practitioners, their staff and patients. One on one consultations mean that the chiropractor is always alone with a patient. Small practices can lead to chiropractors being the only staff member present in a clinic. And the varied hours of clinics will often see practitioners working late at night.

Below are some tips to help you create a safe workplace for everyone who comes into your practice.

- When booking in a new patient who you know nothing about, consider booking them in during a busy time of the day when there are other staff around, rather than when the chiropractor will be in the practice alone.
- If you have a patient who for any reason raises some red flags in terms of the chiropractor's comfort levels, also only allow them to book in when there are others in the practice.
- When a chiropractor is practicing in the evening and is the only person working at that time, consider locking the front door to the practice. If you do this, explain to any patients inside what you're doing and why. And consider your process for other patients who'll be arriving. Will you let them know the door will be locked and that they're to wait outside till you're ready for them? Maybe you'll only lock the door once the final patient for the day has arrived.
- Installing a buzzer on the front door notifies you when it's been opened, thereby allowing you to be sure when people are entering your practice.
- Consider walking patients and colleagues to their cars when it's late, however be sure to consider your own safety when doing this.
- Unfortunately, chiropractors sometimes will be faced with the challenging situation of a patient asking them out or suggesting a romantic relationship begin. Often when this happens, the patient isn't aware that relationships

- between practitioners and patients isn't allowed. Thinking about this situation before it occurs and having a plan for what to say and do can make it easier for the chiropractor to deal with it immediately and professionally.
- If the practice is in the home of the chiropractor, have processes in place to separate the living space from the practice and therefore protect the privacy and safety of the practitioner.
- Keep records of any uncomfortable, challenging or threatening behaviours from patients, and be sure to save anything that's received via text or email. This information is to be recorded in the patient record. The details on what occurred can be brief yet must be professional, keeping in mind records can be seen by others.
- Discuss any challenging or awkward situations with your colleagues or other chiropractors and even other healthcare professionals. This not only provides support when dealing with challenging situations, it also can provide additional tips for how to manage these situations.
- If you'd like some assistance to deal with a challenging patient who's making you feel uncomfortable or threatened, contact the Australian Chiropractors Association for advice and support.

You said what? Appropriate conversations in chiropractic

Complaints of wrongdoing against chiropractors aren't always about the treatment provided or the clinical outcome. Guild Insurance sees numerous cases annually which relate to the professional behaviour and conduct of a chiropractor. This sort of complaint may initially seem less serious than those relating to poor clinical outcomes, however, having your professional conduct questioned and issues raised about inappropriate behaviour towards patients can be incredibly distressing.

Some of these professional conduct complaints relate to conversations, both during and outside of the consultation. Once investigated, it's usually found that the chiropractor in no way intended to breach any professional boundaries or make the patient feel uncomfortable. However this is what's occurred. The information below has been created to assist chiropractors understand what they should be doing and saying differently to avoid facing a complaint similar to the following examples.

Examples of inappropriate conversations

- A patient complained alleging the chiropractor made them feel uncomfortable by asking questions about being a single parent. The chiropractor claimed it was only done to understand more about the patient's lifestyle, however the patient felt judged by the chiropractor.
- A patient complained of feeling uncomfortable as the chiropractor lowered the patient's pants during treatment without consent. Following investigation, it was found the treatment provided and lowering the patient's pants was, in this instance, clinically justified. However, distracted by a chat they were having about weekend activities, the chiropractor forgot to continually talk to the patient about treatment and didn't seek the patient's informed consent before moving clothing.
- A patient complained about questions the chiropractor asked about dating. The chiropractor claimed the conversation was just intended as a friendly chat, however the patient felt the chiropractor was trying to initiate an intimate relationship.

Tips about professional conversations

- **Don't become too friendly with your patients.** While it's clinically beneficial to build a rapport with patients, a professional boundary needs to be maintained. And this boundary means there are conversations you would have with a friend or family member which you shouldn't have with a patient. Conversations should be had in a professional manner so avoid becoming too casual, relaxed or jokey when talking to patients. Often comments made in light humour, or to build rapport, can lead to difficult situations and potentially embarrassing accusations or reputation damaging conditions on your registration. What may be funny to you may not be to someone else. The relationship with a patient should always remain a professional one; keeping in mind the patient is paying for a healthcare consultation not a social chit-chat.
- **Limit non-professional or nontreatment related conversations.** These types of conversations can easily complicate and confuse a professional situation. When a practitioner asks personal questions of their patient, this is most likely intended to just be a friendly chat. However patients often report being confused and uncomfortable and don't understand why they're being asked questions not related to treatment. While some conversations may be fine, such as asking how a person's weekend was, things can easily change when more questions are asked, such as about the partner they spent the weekend with.
- **Explain to patients why questions are being asked.** If you do need to ask some personal or lifestyle questions to assist with history taking or to better understand an injury or pain, be careful to explain why you're asking.
- **Don't forget to keep talking about treatment.** When non-treatment related discussions are had, this detracts from time which should be spent discussing treatment. The discussion about treatment shouldn't just be had at the beginning of the consultation, it's an ongoing conversation throughout. Not only can chats about something other than treatment make a patient feel uncomfortable, it may also mean the patient isn't fully informed about their treatment.
- **Consider the situation of the patient during a conversation.** During treatment, patients are often sitting or lying in positions which may make them feel vulnerable or exposed. Personal conversations had during this time are likely to compound the uncomfortable feeling. Keep in mind a patient could easily misinterpret the intentions behind your questions or conversation if they're already feeling uneasy.
- **Consider the method of communication.** SMS, email and other forms of electronic communication encourage brief messages and don't often adequately convey the full intent or tone of the message. Therefore, if communicating in this way, practitioners need to be mindful that patients may easily misinterpret the message and make assumptions. Also, don't forget that electronic communication, as with all communication with a patient, needs to form part of the clinical record for that patient.

Obtaining informed consent from patients

All health practitioners would be well aware of their requirements to obtain informed consent from their patients before assessment or treatment takes place. However, Guild Insurance's vast experience in managing claims made against health practitioners has highlighted that many practitioners don't meet all their informed consent requirements.

What is informed consent?

There is an explanation about informed consent in the Code of Conduct for each of the professions regulated by AHPRA. In this document, informed consent is defined as 'a person's voluntary decision about healthcare that is made with knowledge and understanding of the benefits and risks involved'. This statement highlights the difference between consent and informed consent. If a patient hasn't been made aware of the benefits and risks, their consent isn't informed.

Informed consent isn't just required for treatment. Depending on the nature of the healthcare being provided, informed consent should also be obtained for assessment.

Informed consent and insurance claims

Informed consent can feature in insurance claims against practitioners in a couple of ways.

It's not uncommon when a patient is unhappy following treatment for them to allege they weren't made aware of the risks when they consented to treatment. Quite often they will allege the treatment was negligent and has resulted in harm or suffering. They then add that had they been informed of the possible risks, they wouldn't have consented.

In other cases, patients may not make any allegation about consent, their complaint might solely focus on the clinical outcome, yet when their claim is being managed it's found that they didn't give their informed consent prior to treatment being provided. When this occurs, it makes it challenging for Guild to prove that the practitioner has treated appropriately and met their requirements.

The informed consent conversation

Informed consent requires a conversation between the treating practitioner and the patient. This conversation needs to occur prior to assessment and treatment.

The conversation must:

- Detail the recommended assessment and treatment as well as alternate treatment options.
- Include the expected benefits of that treatment.
- Provide information about the risks of the treatment.
- Allow time for the patient to ask questions.
- Be held in language which can be understood by the patient which means practitioners should avoid technical clinical language.
- Take place in a private area where the patient will feel comfortable being open and honest about their health situation.
- Be tailored to that individual patient and their unique clinical needs.

Recording informed consent

It's imperative that practitioners make a note in the clinical record regarding the patient providing their informed consent. This needs to be more than 'IC given'. The record needs to show what treatment options and risks were discussed as well as any questions asked by the patient. The record should also show what the patient consented to as well as what they didn't consent to where relevant.

The informed consent form

One area which leads to some confusion about informed consent is how to use an informed consent form. Having a patient sign a form is seen as a quick and simplified way of having a patient provide their informed consent and keeping a record of that. However, they are unfortunately too often used inappropriately.

Signed forms aren't a requirement. While recording consent is required, this doesn't need to be done using a form. Notes in the clinical record are sufficient. However, signed forms do provide additional evidence if there is an allegation that informed consent wasn't given.

Forms can't be used to replace the informed consent conversation. A patient cannot read a form and gain the same level of understanding as they would from a conversation with the practitioner. Nor can they ask questions of the form.

A form should only be signed after the conversation with the practitioner has been had and the patient understands what it is they're consenting to. Patients are occasionally asked to sign consent forms at reception before they've seen the practitioner. As there has been no assessment or discussion about treatment at this stage, this can't be considered informed consent as the patient hasn't been informed.

Some practices combine new patient forms with the consent form. This isn't ideal as the two forms serve different purposes. Also, having them on the one form encourages patients to sign the consent form at reception before they've seen the practitioner. Therefore, they should be divided into two separate forms.

Informed consent is not a one-off event

Practitioners regularly ask how often their patients need to give informed consent. There is no set time frame for when informed consent conversations or signed forms need to be repeated. The requirement is that when a patient is receiving any assessment or treatment, they need to have given their informed consent to this. Therefore, informed consent should be an ongoing process; it's a continual conversation with patients during consultations. And when there is any change in the treatment being provided, or if the patient has returned following a period of absence, informed consent needs to be revisited. A general 'consent to all treatment' for the life of the therapeutic relationship is not appropriate.

Informed financial consent

As well as consenting to assessment and treatment, patients should also give their informed financial consent. This means they need to be provided with information about the expected cost of treatment before this treatment commences.

In summary…

There is no one right way to undertake an informed consent conversation and process. Practitioners must adapt what's discussed for the patient they're treating and that patient's unique circumstances. However, what must occur in all cases is that the patient is informed of and understands the proposed treatment, alternate treatment options and the risks involved. Only with this information can they give their informed consent. The practitioner must also be sure to make a record of this informed consent discussion in the clinical record.

Let the record show

Clinical record keeping is unfortunately one of those dreaded risk management topics. Guild Insurance understands that it isn't the most interesting of topics for health practitioners to spend time thinking and talking about. However, it is incredibly important, and Guild's experience suggests many health practitioners would benefit from learning more about good record keeping.

Clinical records and insurance claims

Clinical records can impact insurance claims in two ways:

1. Poor records can contribute to a poor or unexpected outcome following treatment, leading to the patient complaining and possibly seeking some form of compensation.
2. Poor records may make a complaint, and therefore an insurance claim, difficult to defend due to the lack of evidence.

All health practitioners would want to avoid poor clinical outcomes as the wellbeing of their patients is paramount. However, they would also want to avoid complaints, which can lead to insurance claims, as these can be very challenging and confronting experiences.Therefore, understanding how to improve the standard of clinical records really should be a focus.

Why keep detailed clinical records?

1. Continuity of patient care

It's not uncommon to hear health practitioners believe they can remember the details of patient consultations. However at Guild, we regularly see examples where practitioners haven't remembered key aspects of prior consultations and treatment, and this has led to a poor outcome for the patient. It's therefore imperative to have this information recorded to ensure certainty as to how and why you've treated a patient in the past.

It's also important to be sure you refer to the information within the patient's record. Patients can suffer harm when information, such as allergy details, is overlooked or forgotten about and therefore the patient isn't treated accordingly.

2. Regulatory requirement

All Australian Health Practitioner Regulation Agency (AHPRA) regulated practitioners need to be well aware of their many regulatory requirements; good record keeping is one of these. All National Boards within AHPRA have produced a Code of Conduct for the relevant profession. Within this code is information about a practitioner's obligations and requirements regarding record keeping. A number of National Boards have also created a separate document on guidelines for clinical records which further explains what is required.

It is the responsibility of every registered health professional to make themselves aware of and comply with the various codes, guidelines and policies relevant to them. Not knowing is not an excuse for not complying.

3. Defence of a complaint

If there is any allegation of wrong doing made against a practitioner, their records are going to be incredibly important. Those records provide evidence of what took place and why. Without this, the practitioner will be relying on their memory as a defence. Information recorded at the time of the consultation is going to hold greater weight as a reliable defence than a practitioner's memory months after an event. As the saying goes 'Good records = good defence, poor records = poor defence and no records = no defence'.

4. Funding audit

Funding providers, such as private health insurers, regularly review the rebates they pay for healthcare and can conduct audits to be sure health practitioners are billing appropriately.

It's not uncommon for a health practitioner to receive a request from a funding provider to produce clinical records to justify their billing practices. This is another example of when a practitioner needs documented evidence of what they've done and why. If the reasons behind treatment, and therefore billing, isn't clear, funding providers can demand repayment.

What to record?

The key question many health practitioners ask when it comes to clinical record keeping is 'how much detail do I need to record?'. Practitioners should refer to their Board's Code of Conduct, as well as the guidelines on record keeping if one exists, to better understand the detail required in a clinical record.

Exactly what to include can vary according to the type of health profession as well as the specifics of the patient's condition and treatment. However, generally records should include, but aren't limited to:

- Patient identifying details and contact information as well as health history
- Name of the consulting practitioner and the date of the consultation
- Reason for the patient presentation
- All examinations and investigations conducted and their results, even if there is no abnormal finding
- Diagnosis and treatment plan
- Consent to treatment
- Treatment provided and the patient's response
- Any items supplied, or instructions given, to the patient
- Referrals to other health professionals.

In some cases, it's worth noting what didn't occur as well as what did. For example, if a patient has refused to consent to what would be considered the most ideal or obvious treatment option, the record should reflect that it was discussed and declined. If it is simply left out of the record, it would appear that it wasn't discussed as a treatment option.

When a practitioner is unsure if they have included enough detail, they should ask them self whether or not another practitioner could read the record and understand the full picture of what took place and why, without the treating practitioner filling in any gaps. If the full story isn't there, there isn't enough detail.

Professional and objective

Clinical records need to always be professional and objective. Criticisms of the patient can be included, however this must be professional and only when this is relevant to the treatment being provided. This may occur in situations where the patient isn't complying with instructions and this is detrimental to their health. However, it's important to remember that clinical records can be accessed and read by a number of people, including the patient and your regulator, so always be mindful of the language used. The language used should match the professional language a health practitioner would use when speaking to the patient during a consultation.