RACGP Skin Cancer resource list

Please find below some resources for each of the sections that were covered during the RACGP Skin Cancer Risk Management online seminar.

1. Consent resources

Below is a draft of the type of information that is useful to have on an informed consent document.

Use 'consent' in the title of the document

Name of procedure

General explanation of the procedure and how it will benefit the patient

Risks

- As a guide – known risks should be explained when:
  - An adverse outcome is common (even if harm is slight)
  - An adverse outcome is rare, but the harm could be severe.
- Use plain language.
- 1 in 10 may be more readily understood than 10% chance of something happening.
- Highlight those that may be more specific to that individual patient – circle them or write them on the form.
- Ensure all hand-written information is legible.

Alternatives

Patient questions - including an explanation that they can ask them at any time up to the point of the procedure - document if there are none also. Having this may help demonstrate what was material to them about the procedure.

- Suggested questions to help elicit a response might include:
  - What is it that concerns you or you are worried about – maybe something that is waking you at night?
  - What would trouble you most about an outcome from this?

Provision of other supporting documentation such as information brochure, websites, videos and post operative wound care information.

Use 'consent' as a verb on the form and obtain the patients name, signature and date.

Doctor details, printed name, signature and date.

If ever brought into question, proving that you have provided informed consent will include the sum of information: the consent form as well as the documentation of the discussion in the medical records and any information brochures provided.

The things you need to have recorded should be enough to allow you to establish what advice and information you provided to the patient.

Some other important points are as follows.

- The form should be completed during the discussion with the patient and marked up as appropriate to the individual patient's situation and the discussion that occurred.
- It is not sufficient to merely document "risks ✓" or "risks explained" without having a record of the discussion. Making notations on the form if you utilise one, helps to evidence the discussion.
- Ensure the form, or an accurate copy is included in the medical record.
- Be careful of using a standardized dump of information in your records – they need to demonstrate the discussion was salient to that patient.

Keep a register of educational material, ensuring you do not overwrite old versions with new ones. This will assist you (if you are ever questioned) to identify precisely what information has been provided to a patient.

Often, in the absence of adequate documentation, a practitioner may say that their usual practice is to provide the relevant information. If there are written policies and procedures that provide a checklist or process for ensuring a patient is informed of the information relevant to a particular treatment or procedure (and this is referenced in the health record) it can be confirmation that this usual practice was indeed undertaken with the patient in question.

The medical practitioner performing the procedure should not assume that someone else has properly informed the patient and obtained a valid consent. If you are performing the procedure, you should:

- verbally confirm that the patient understands the procedure,
- ensure that the material risks (relative to the patient's history) have been discussed prior to the procedure commencing and that they have no outstanding questions.

Generally, you should not rely on a nurse, allied health practitioner or administrative staff member to undertake the consent process for invasive procedures.

Other resources:

MIGA What is informed consent?

RACGP Information sheet: Informed patient decisions

2. Chaperone resources

MIGA Managing risk with chaperones resource

The AMA Patient examination guidelines also provides useful guidance on chaperones in Section 5.

3. Communication resources

Communication is a core clinical skill that is not always prioritised as it should be. it can be developed and improved with practice and support.

"Good doctor-patient communication has the potential to help regulate patients' emotions, facilitate comprehension of medical information, and allow for better identification of patients' needs, perceptions, and expectations. Patients reporting good communication with their doctor are more likely to be satisfied with their care, and especially to share pertinent information for accurate diagnosis of their problems, follow advice, and adhere to the prescribed treatment."

Ha JF and Longnecker N (2010) Doctor-patient communication: a review. Ochsner J. Spring; 10(1):38-43.

Australian research found that the most substantial factor associated with both a positive and a negative patient experience was the existence and degree of effective communication between health care practitioners and patients.[1]

Effective communication skills are also associated with optimal clinical outcomes and higher patient and clinician satisfaction. Communication failures on the other hand may lead to poor care outcomes, untrusting and unhappy patients. [2]

MIGA provide education on communication including workshops, modules and practice self-assessments, that you can access if you are a MIGA member.

4. Follow -up resources

MIGA Patient follow-up

Criterion GP2.2 – Follow-up systems **provides practical tips on meeting the requirements of this indicator in General Practice.**

5. Medicare resources

The following links provides useful information on Medicare billing for skin lesions including keeping evidence and determining the lesion size for item number selection.

MBS eLearning Skin lesions - includes resources on the following

- Consultation items and the treatment of skin lesions
- Skin lesion excision and local flap repair
- Treatment of skin lesions – other than excision
- Treatment of skin lesions – case studies and knowledge checks

Services Australia - Billing skin lesion treatment and biopsy items under Medicare

[1] Harrison R et al (2015) Patients' experiences in Australian hospitals: An evidence check rapid review brokered by the Sax Institute for the Australian Commission on Safety and Quality in Health Care

[2] Kapadia MR & Kieran K (2020) Being affable, available, and able is not enough: Prioritising surgeon-patient communication. JAMA Surg; 155(4):277–278

Services Australia – Health Professional Education Resources - once in this link, there are a number of tiles you can choose from that you may find useful including Medicare Benefits Schedule and Medicare Digital Claiming. Each will take you to further resources including the MBS tile which takes you to eLearning on aftercare and post-operative treatment and billing.

Services Australia – Aftercare or post-operative treatment

If you are looking for more personalized assistance, you email the Business Development Officers on OSOS.Strategy@servicesaustralia.gov.au and they will get in contact with you to arrange a site visit with you so you can be certain you are doing everything as you are supposed to be.

In general, it is worth reading the Explanatory notes attached to item numbers instructive.

Medicare's Administrative Record Keeping Guidelines provides further information on what needs to be included to ensure the MBS item descriptor requirements are evidenced as being met for correct benefits to be payable

6. Medical Records resources

MIGA Bulletin article "Spoken words fly away, written words remain" looks at tips on ensuring your medical records assist you and your patients.

It is important that you are confident that your notes demonstrate your clinical decision making. Even if you're found later to be wrong, having it documented can make it easier to obtain a supportive expert opinion, even if they don't agree with what you have done.

The following issues summarise some of the areas of vulnerability associated with electronic health records.

- *Information overload:* don't keep cutting and pasting repetitive information as this can bury important information
- *Incorrect information*: if the wrong template is used, or information is cut and paste from another source, the record may become confused and/or inaccurate
- *Patient mix-ups:* MIGA have seen cases where information is entered into the wrong record as the previous one was not closed down. We have also seen scanned documents in the wrong records. Finish with each patients record before you see another patient and do regular scanning checks.
- *Privacy and Security*: maintain confidence in your soft and hardware including contracts related to privacy and cybersecurity. Ensure clinical images, emails and text messages make their way into the health record promptly and are removed from the original device.
- *Inattention to patient:* be mindful of how much time you spend looking at the computer versus paying attention to the patient.

Continual reflection on the quality of your records is something that should be built into your daily routine.