



Practice MATTERS

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THE DANGERS OF POLYPHARMACY AND DRUG INTERACTIONS

How to manage the risk

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ADVICE FOR VOLUNTEERING SPORTS PHYSICIANS

What are the medicolegal
implications?

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The ethical dilemma of prescribing
to minors

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We welcome contributions to *Practice Matters*, so if you want to get involved, please contact us on **+44 113 241 0221** or email: publications@medicalprotection.org

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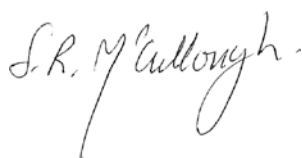
ello and welcome to the latest edition of *Practice Matters*, a magazine for the whole general practice team.

On page 6, Dr Paul Bowie and colleagues discuss Significant Event Analysis (SEA). They consider the human factor in adverse events and suggest ways to assist in preventing such incidents occurring in the future. In addition, Diane Baylis explains the ethos behind Never Events on page 12, and how we can approach them proactively to ensure that both patients and practices are safeguarded against them.

This issue also considers prescribing, and the various medicolegal risks that come with it. On page 16, Dr Diarmuid Quinlan explains the danger of prescribing multiple medications to one patient, and on page 18 I discuss a case in which a practitioner faces the ethical dilemma of prescribing antidepressants to a minor.

In addition in this issue, Julie Price looks at the potential pitfalls of test result handling and management on page 10, and provides some safeguarding advice and robust practices to implement in your unit. And for those of you considering volunteering as a Sports Physician, I discuss some medical legal considerations on page 14. I hope you enjoy this edition of *Practice Matters*. As ever, we are keen to hear what our members think, and we welcome any feedback, queries or suggestions that you may have.

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Dr Sonya McCullough
– Editor-in-Chief

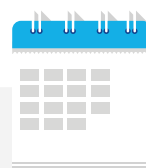


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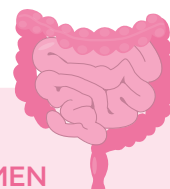
EQUIP PATIENT SAFETY CONFERENCE A SUCCESS

The ICGP-run EQUIP European Patient Safety Conference, in partnership with Medical Protection, was held in March at the Royal Marine hotel in Dun Laoghaire. The conference covered measuring and monitoring safety in primary care, implementing safety using tools for general practice and policy and safety culture, amongst others. For a full round up of the event, please visit icgp.ie.



NEW WORKSHOP DATES

New dates have been announced for Medical Protection's educational workshops. The workshops are free to attend as a benefit of membership and cover topics such as professional interactions, adverse outcomes, medical records and shared decision making. For more information or to book your place, please visit medicalprotection.org and select the 'Education and Events' tab.



ANEURYSM SCREENING FOR MEN LAUNCHED IN CORK

A screening programme for abdominal aortic aneurysms (AAA) has been introduced to five GP practices across Cork, following success in the UK. The screening, which is performed by ultrasound, began in February. Dr Diarmuid Quinlan gave a presentation on AAA at the EQUIP European Patient Safety Conference in March.



WANT TO WRITE FOR US?

Medical Protection is your organisation and we want you to be part of it. We are currently seeking new contributors to submit well-crafted and informative feature articles for *Practice Matters*. If you would like to have your writing published, or if you have any ideas for content, please contact our editorial team at publications@medicalprotection.org

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LEARNING FROM EVENTS

Significant event analysis (SEA) is commonly used to enhance safety in general practice – but can the method be improved by paying consideration to human factors? Paul Bowie, Kate Taylor and Julie Price discuss

READ THIS ARTICLE TO:



- ✓ Discover why SEAs can be ineffective.
- ✓ Learn how to make SEAs more effective.
- ✓ Find out about PaCE analysis and how to apply it.

Significant event analysis (SEA) is a well-established safety improvement tool¹, but there is good evidence to suggest that many SEAs (involving patient safety incidents²) could be conducted more effectively. This relative 'inefficiency' can lead to missed opportunities to make systems safer and to reduce frustration in the workplace.³ The issue stems from a number of factors:

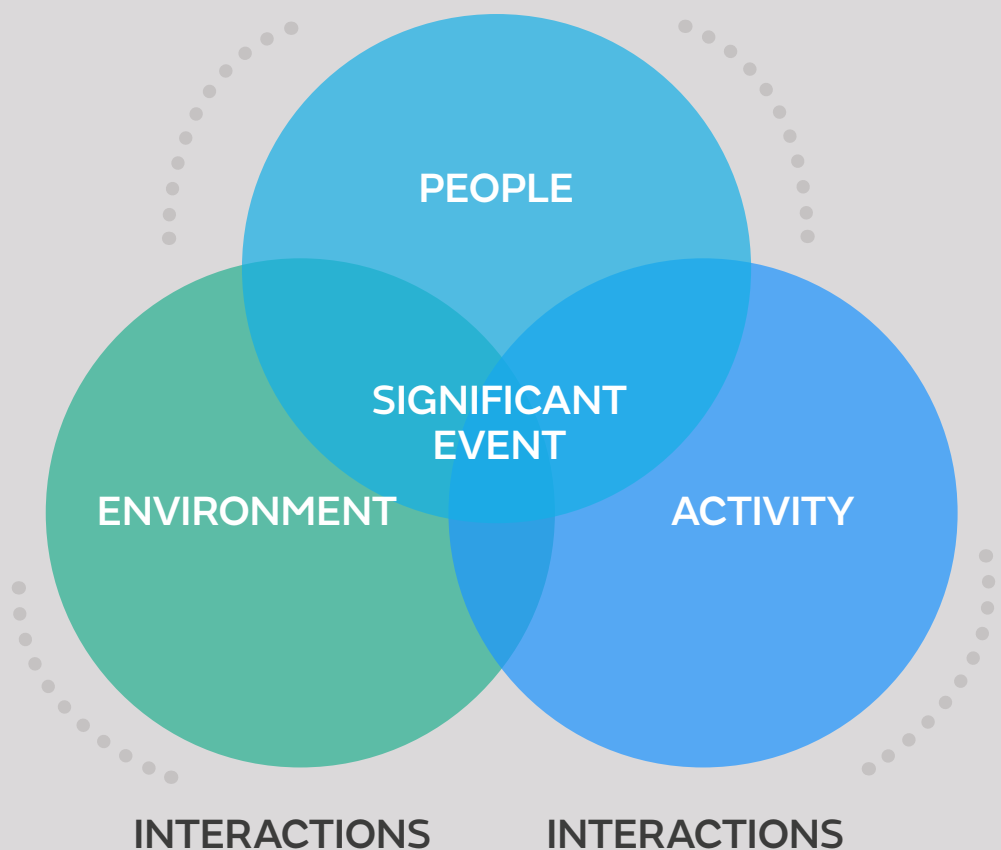
- Being involved in a significant event can be similar to receiving negative feedback; the emotive reaction to it can interfere with the ability to process the information⁴. The emotional wellbeing of GPs involved may suffer as a result – the so-called 'second victim' syndrome.⁴
- 'Blame culture' is widely perceived within the HSE which can be a barrier to building support networks^{5,6}. In turn, this can impact on the willingness of clinicians to highlight patient safety issues because of concerns about punitive action or professional embarrassment³. Many practitioners can be selective in the types of safety incidents they raise for team-based analysis, potentially ignoring those of a complex, serious or sensitive nature.³
- The lack of an analytical framework to guide teams when reviewing significant events², which can, in turn, hinder effective learning and improvement. A good framework is imperative; many clinicians tend to view the 'causes' of incidents as being attributable to their own actions. This is contradictory to human error theory – more on this later.

ENHANCING SEA

A recent project led by NHS Education for Scotland⁸ attempted to address these problems by designing an 'enhanced' SEA method, underpinned by basic human factor principles. Think about the interactions between three related factors (Figure 1): People, Activity and Environment (PaCE) – and how, combined, they impact on performance and wellbeing. Ultimately, it is these system interactions that contribute to things going wrong in the workplace.

INTERACTIONS

Figure 1



PEOPLE	ENVIRONMENT	ACTIVITY
<ul style="list-style-type: none"> • Individual: competence, skills, attitudes, risk perception, training • Care team: roles, support, communication, leadership • Patient: clinical condition as well as physical, social, psychological and relationship factors • Others: other health and social services. 	<ul style="list-style-type: none"> • Work process: if processes are not up-to-date, not available, unclear/unusable or not followed • Design or organisation of processes and systems: level of complexity, workload or poor system design • Technology and equipment: such as usability issues. 	<ul style="list-style-type: none"> • Work setting: staffing, environmental conditions, workload, physical environment, administration or time factors • Organisational: safety culture, priorities, external risks • Communication: both verbal and non-verbal • Education and training: supervision and competence.

APPLYING PACE ANALYSIS

At the core of understanding human factors is undertaking a systematic approach to problem solving; applying this to the SEA process allows the practice team to gain a deeper understanding of why things go wrong. Using a basic systems-centred framework like PACE can help depersonalise the incident and focus attention on the 'true' contributory factors⁷: how the complexity of work tasks, systems and wider organisational issues can interact with the human element in the practice to increase the risk of things going wrong. It is really important that we involve team members at all levels in this process – we all have multiple perspectives on how a system works and how it can be improved. Once we identify these factors, we should prioritise those of greatest importance before deciding on the best course of improvement. The 'litmus test' will be the confidence within the team that changes will minimise the risk of an event reoccurring (or the impact of a reoccurrence).

CONCLUSION

Enhanced SEA is based on sound educational principles. It is a key tool, among others, that promotes and builds an effective system and facilitates change for improvement. It also encourages a culture of honesty in the team, not to mention individual and team-based reflection. To ensure the investigation of significant events is meaningful, consideration of the emotional demands involved in coping with the event (at the individual level) and the most effective way to analyse this (at the team level) is critical in successfully improving patient safety and the wellbeing of the practice team.



CASE STUDY

The following demonstrates the practical application of PACE, and the educational outcomes for a practice team.

Mr M, a 58-year-old man, collapsed in the waiting room while attending a routine appointment at his GP's surgery with his wife. The emergency alarm was immediately activated by the receptionist, who then called an ambulance. The practice team responded as per the emergency protocol; Dr C retrieved the emergency equipment and examined Mr M. It was clear that life-saving treatment was necessary, but Dr C could not get the defibrillator to turn on. Manual CPR was commenced, but was made awkward as Mr M was a large man and the space was confined. The practice nurse was attending to Mr M's distressed wife, and administrative staff were moving attending patients (including the elderly and infirm) to an adjacent corridor. The patient was also given the available adrenaline, although it was noted and heard that this was out-of-date. The ambulance arrived shortly after, and the attending paramedics stabilised Mr M and transferred him to hospital care, where he made a full recovery.

After the event, it was discovered that two team members – including Dr C – were overdue mandatory CPR refresher training. A formal complaint was received by the practice about the standard of emergency care.

Impact

The impacts were on Mr M and his wife, who were distressed and filed a complaint, and on the team, who felt anxiety and embarrassment at the situation and suffered adverse local publicity.

Factors

The contributory factors were as follows:

- **People** – physically large patient; emotional family member; fatigued clinicians; full waiting room
- **Activity** – emergency alarm activated; rapid response required; unusual and physically demanding task; defibrillator unusable and resulting minor confusion; stock of adrenaline available but out-of-date
- **Environment** – small waiting room; distractions from waiting patients; heavy workload impacting on delayed CPR training; ad-hoc checking process for emergency equipment and drugs; practice that did not prioritise checking processes;

decreased budget which led to delayed decision on replacing the defibrillator.

System overview

The key learning focus is on the need for the timely and systematic checking of safety-critical issues, such as training and emergency equipment.

Improvement to minimise risks

Using the PACE assessment system, the team:

- issued an apology to Mr M and his wife
- sent the relevant staff to undergo CPR refresher training
- replaced the emergency equipment and drug supply
- implemented a formal checklist to be used on a four-month cycle – the results of which were to be reported on a 'run chart' on the staffroom noticeboard and discussed at meetings.

Medical Protection offers a workshop on the issues raised in this article, called Learning from Events in General Practice. Please visit medicalprotection.org for more information.

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MANAGING CONFLICT

IN GENERAL PRACTICE

Suzanne Creed explains how to increase your understanding of conflict, and provides some strategies to deal with it more effectively

READ THIS ARTICLE TO: ✓

- ✓ Find out why conflict and aggression is a prevalent issue in general practice.
- ✓ Learn strategies to avoid aggression escalating.
- ✓ Discover tips for effective communication.

All members of the general practice team have the right to work in an environment free of harassment and threat; nobody should have to tolerate the threat of verbal or physical abuse. Unfortunately, conflict and aggression do occur in general practice – the environment is busy and demanding, and involves contact with a wide range of people in varying circumstances. Patients sometimes have unrealistic expectations of care, and when these expectations aren't met, a conflicting situation may arise.

Any conflict or aggression usually starts with a minor disagreement and may escalate, so the key to managing such situations is to de-escalate them.

THE SCALE OF THE PROBLEM

In 2015, Medical Protection surveyed 254 GP members, 52% of whom experienced challenging interactions with patients on a weekly basis¹. This is mostly attributed to unrealistic patient expectations (72%), followed by alcohol/drug misuse by the patient (41%).

An Irish survey (2011) of 81 GPs in out-of-hours (OOH) services found that a significant number had experienced harassment and assault².

- 51% had been abused.
- 47% had experienced intimidation or harassment by a patient.
- 30% felt their safety had been compromised in the past.

It is more likely that staff working in general practice will be subjected to non-physical

violence, but we must not underestimate the impact that violence of this nature can have on an individual. It can result in loss of confidence and can also increase feelings of insecurity, loss of control or panic, which can ultimately have an impact on staff morale.

Conflict means different things to different people – some people may enjoy a heated discussion where others may find it upsetting. The Health and Safety Authority describes workplace violence as “where people in the course of their employment are aggressively verbally abused, threatened or physically assaulted.”³

WHY IS THERE A RISK OF VIOLENCE WITHIN GENERAL PRACTICE?

Aggression does not usually develop suddenly or in isolation, and violence and aggression in healthcare can differ greatly to other workplace environments. As healthcare workers, we interact closely with patients and their loved ones, often in very challenging circumstances. Patients may respond aggressively to a medical condition, medication, psychological state or due to disability. Members of the practice team are particularly vulnerable to violence as they are often consulting with patients alone, in small numbers within the premises or on house calls.

There are other contributing factors which may escalate conflict situations further, such as:

System issues

- delays in appointment times or test results
- errors, such as lost prescriptions
- difficulty in accessing other services.

Environmental

- waiting and consulting room conditions
- lack of privacy in areas like reception
- increased or disproportionate expectations
- dissatisfaction with the care provided
- a potential underlying medical condition, such as hypoglycaemia or psychotic illness
- communication issues and language barriers
- strong patient emotions



Aggression does not usually develop suddenly or in isolation, and violence and aggression in healthcare can differ greatly from in other workplace environments

- physical pain causing frustration
- mental health issues
- personal problems and anxieties
- drug and/or alcohol dependency.

Staff

- pressure, lack of support
- inadequate staff numbers
- potentially escalating the situation by overreacting, communicating poorly, handling patients inconsistently, being patronising, ignoring a situation or failing to apologise.

KEY STRATEGIES FOR AVOIDING ESCALATION

Good communication and attention to detail are essential in reducing the risk of conflict; practice staff should approach patients with a friendly manner which values the patient, acknowledges their individual situation and demonstrates a willingness to help. Remaining focused on addressing the patient's individual needs will make them feel safe and less distressed.

A study by American psychologist Albert Mehrabian (1971)⁴ determined that our non-verbal communication represents over 50% of an interaction, so being aware of your own body language is important, and can be the first step to understanding how we are perceived by our patients.

Tips for effective communication

- Make a conscious effort to stay calm.
- Approach the patient in a warm and open manner, avoiding confrontational body language such as crossed arms or standing too close.
- Give the patient your undivided attention where possible.
- Do not be patronising.
- Read the patient; observe their emotions and respond to that as well as their words.
- Avoid interrupting.

- Ask questions and reflect your understanding back to the patient.
- Try to find out what the problem is from the patient's point of view; ask open-ended questions such as 'what can I do to help?'
- Acknowledge frustration and the importance of the issue for the person.
- Give clear messages that demonstrate you want to help. Apologise if errors have occurred – an apology goes a long way in diffusing a situation, and is not an admission of liability.
- Utilise a separate room/area to deal with upset patients, or those needing more privacy.
- Ensure the practice has a comfortable temperature and ventilation control, as well as adequate seating and clear signage.
- Ensure patients are well-informed about how your systems work to reduce unrealistic expectations.
- Add a practice-agreed marker to the summary of a patient's record who has a history of violence (always ensure this is factually accurate).
- Have a practice protocol for involving the Gardaí and removing patients from the list.
- Ensure the practice has access to panic alarms, and a plan in place for if they are activated.
- Ensure that locks are installed in areas where patient access should be restricted.

Tips for House Calls

Inform staff at the surgery where you are going and your anticipated time of return (or if you are working out-of-hours, advise the driver of the same).

Carry out a risk assessment before agreeing to see any patients with a history of violence, alcohol/substance misuse or mental illness. If

there is a potential risk to your safety, it may be important to inform the Gardaí and have them support you on your visit.

- Have access to a mobile phone.
- Consider carrying a personal alarm.
- Park as near to the destination as possible.
- Consider the safety of prescription pads and narcotics; keep drugs locked out of sight if possible, such as in the boot of a car.

ACHIEVING A SOLUTION

Once a problem has been highlighted, the key to a successful outcome is a mutually agreeable solution. Do not promise what you cannot deliver; provide choices and use timeframes where possible, and always offer an alternative rather than a refusal.

We can, and will, experience conflict at many times in our professional lives due to the sheer volume of patient contact that occurs every day. Early detection and de-escalating a situation is crucial to preventing violent behaviour. Remember that your personal safety is the highest priority.

Medical Protection has developed a Managing Conflict and Aggression in General Practice workshop, which will assist your team in recognising and managing different aspects of conflict that they may encounter at work. For further information, visit medicalprotection.org

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THE RISKS OF TEST RESULT MANAGEMENT

Like many risks in general practice, the effective management of test results is threatened by both a lack of robust systems and the potential for human error.

Julie Price explains

READ THIS ARTICLE TO:



- ✓ Understand the threats to effective test result management.
- ✓ Learn tips for implementing a robust test result system.
- ✓ Appreciate the importance of communication in test result management.

The test result management process is a complex journey of many steps where there is a potential for significant error, from ordering to monitoring the patient through follow up. Well-designed test results systems can trap human errors and help reduce the likelihood of adverse events, thus preventing harm to patients. Below are some risk management tips for each step to ensure your test result process is safe and robust.

STEP 1: ORDERING OF TESTS

Errors associated with test ordering include failure to order the test and ordering an incorrect test.

When a clinician makes a decision to obtain a test, this should be clearly communicated to the appropriate staff member, such as the nurse or phlebotomist. This should ideally be done through the appropriate computer software, rather than using free text which is open to error and misinterpretation.

Clinicians should document the type of test(s) required during the patient encounter and all relevant technical information in the clinical record. This is to ensure that the person undertaking the test has clear explicit instructions as to the test required. It is not sufficient to record, for example, 'for normal bloods'.

STEP 2: OBTAINING A SAMPLE

All relevant staff should be trained and competent to undertake venepuncture. The procedure should be explained to the patient, including risks and benefits, to ensure the patient understands the procedure. The patient's consent should be documented in their medical records.

Personal protective equipment (PPE), such as gloves and aprons, should be provided for practice staff and worn when indicated. Details of when to wear PPE should be included in the practice infection control policy.

Samples must be placed into the correct container for the type of examination requested. All containers must be labelled with correct patient identification and must match the information on the requesting form.

Consider providing the patient with a list of the samples that they have had taken (a tick box on a pre-printed sheet) along with the usual timescale.

STEP 3: ADMINISTRATION OF SAMPLES

One of the challenges for practices is ensuring that all the samples that are sent off to the laboratory are returned as results.

Practices may consider undertaking an audit of the ins and outs of patient samples sent to the laboratory to ensure that all results are returned.

STEP 4: TRANSPORTATION OF SAMPLES TO THE LABORATORY

Specimens must be transported in a rigid, robust, leak-proof container with a tight fitting lid. This container must be identified with a biohazard sticker and a contact telephone number in case the box is mislaid or lost. Clinical staff must not transport specimens unless such a container is used.

All staff should be aware of the correct procedures for storing samples prior to transporting them to the laboratory. A designated member of staff should check on a daily basis all refrigerators and storage locations before the laboratory transport leaves.

STEP 5: MANAGING RESULTS RETURNED TO THE PRACTICE

Unclear or ambiguous test result communication by doctors can lead to uncertainty amongst other team members about what action needs to take place and what should be communicated to patients.

Practices need to have a process for reviewing results within clinically appropriate timescales, agreed within the practice. They must also have a robust process for actioning emergency test results communicated by the laboratory. Practice IT systems should enable laboratory inputs to be work-flowed, reviewed and commented on by the appropriate clinician.

STEP 6: CLINICAL REVIEW OF LABORATORY RESULTS

Practices should ensure that all results are reviewed by a clinician (including those marked as 'normal') before being filed in the patient's records. The reviewing clinician is responsible for ensuring that results that alter patient management are acted on.

A buddy system should be in place so that no results are missed when staff are absent from the practice. Practices should ensure there is such a system in place whereby, when a clinician is not available, another GP checks the results, thus making sure no urgent abnormal results are overlooked, or the necessary immediate response delayed.



STEP 7: RESULTS ACTIONED OR FILED

Failure to follow up test results has been identified as a major problem in primary care settings. The resulting effects can be serious lapses in patient care including delays to diagnosis and effective treatment.

The responsibility for the actioning of results lies with the practice. It should not be assumed that the patient will phone up the practice to find out if any action is necessary following tests. The practice should have a system in place to ensure that the patient is contacted so that the desired action is carried out, such as a follow-up test, investigation or review. Normal results may prompt an action as well as abnormal results, for example stopping iron after a normal ferritin.

The use of SMS messages can appear an efficient and attractive way of communicating with patients. However, Medical Protection suggest that this mode of communication is restricted to non-clinical matters such as appointment reminders, vaccine recalls, smear recalls, etc.²

STEP 8: PATIENT MONITORED THROUGH FOLLOW-UP

A lack of appropriate follow-up may lead to a delay in diagnosis. Some practices may have no reliable method for practitioners to check that a patient has attended their follow-up appointment.

Practices should consider introducing either a manual or computerised tracking system to ensure that patients' test results are adequately followed up. Many clinicians use the 'task' function on the computer as a reminder, for example, sending themselves a 'task' to check later that the patient was followed up.

The practice needs to be certain that all the actions that need to occur, as the result of investigations, are completed and that all patients are fully informed of the implications of investigation findings.

TEST RESULT PROTOCOL

Once the process has been agreed, this should be documented in a practice protocol. The test result protocol should be read by all relevant members of the practice, and staff should sign to confirm that this is the case. Staff should be trained in the process. The system should be audited regularly to ensure that it is functioning as it should, and to consider whether any changes or improvements are required from the learning gained.

MORE SUPPORT

Medical Protection has developed an online self-assessment tool, Test Result 360, to assist practices in ensuring their system is robust. To find out more and register, visit: **medicalprotection.org** and search '360 tool'.

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NEVER EVENTS IN GENERAL PRACTICE

Diane Baylis, Medical Protection's Clinical Risk and Education Manager, explains what a Never Events list is, and how to develop one for your practice

READ THIS ARTICLE TO:



- ✓ Learn what a Never Events list is.
- ✓ Find out about research into serious adverse events that occur in general practice.
- ✓ Discover how to create a Never Events list for your practice.

Patient safety is at the forefront of ensuring the provision of high quality healthcare¹. The terms 'quality' and 'safety' are increasingly used synonymously, and attaining a high level of safety is an essential step in improving the quality of care. This is becoming more challenging in general practice though, particularly when confronted with unprecedented financial challenges and rising service demand².

There is growing international evidence that, by adopting similar strategies to other high risk industries, healthcare organisations can reduce variation and therefore improve patient safety³.

WHAT IS A NEVER EVENTS LIST?

A Never Events list is a definitive list of serious medical errors which are deemed to be preventable and therefore should never occur⁴. Never Events lists are used worldwide in healthcare to increase understanding and knowledge of potentially serious patient safety incidents, and to apply relevant precautionary measures to improve patient safety⁵.

The ultimate aim of a Never Events list is to improve patient safety by preventing the incident from happening.

RESEARCH APPROACH

Research was conducted looking at serious adverse events, with the aim of developing a list of Never Events specifically for general practice. A review of previous research highlighted the importance of incident reporting with regards to patient safety⁶. It also supported the claim that serious adverse events in general practice can be classified as Never Events as they pose an equal risk to patient safety⁷. Most of the research into improving patient safety in healthcare has previously focused predominantly on hospital care⁶ – research into adverse events in general practice has received significantly less priority⁸.

GPs from the North West of England were invited to take part in an online survey to give their opinion on whether a specific incident should be included on the Never Events list for general practice (the final list was based on the 103 responses).

FINDINGS

From 54 questions posed to the respondents regarding serious adverse events, a list of 21 Never Events was developed.

The most unanimous Never Event was 'the failure to send a referral of a patient, prompted by a clinical suspicion of cancer'. This received the highest proportion of agreement, indicating a very high awareness among GPs that this is a serious risk and should therefore make the Never Events list.

Incidents relating to prescribing and medication issues were also prevalent on the list, showing that practitioners have a high awareness of the known risks relating to prescribing in general practice.

With regards to these Never Events, it is worth remembering that there are systems and processes in place to prevent them from happening, and sufficient guidance exists to ensure that the incident is entirely preventable in the first place.

Never Events are, then, hypothetical (but vital) indicators that these systems and barriers may, or have potential to, fail.



Comments provided by the GPs who took part in the study served to highlight some key concerns. Common themes that emerged from the comments provided in the survey were:

- The concern that the workload and high pressure environment in general practice increases the likelihood of making a mistake.
- The fact that practices deal with many test results on a daily basis; the degree of urgent response is variable and the impact on patient outcomes can be serious. The failure to follow up test results is recognised as a crucial patient safety issue⁹.
- That adverse events involving communication are frequent and communication errors – particularly through the primary/secondary care interface – often occur due to incorrect or illegible hospital discharge letters.

Recommendations

The study provided a snapshot of opinion, and served to highlight the scale and type of serious adverse events in general practice. (Further research is recommended to review the final list of 21 serious incidents, as some of these are merged for clarity.)

The Never Events established by the survey are listed below. It may be useful to adopt this list within practice to use as a guide for identifying potential serious adverse events, and to put systems and barriers in place to prevent them from occurring.

Acts of omission

1. A planned referral of a patient, prompted by a clinical suspicion of cancer, is not sent.

Investigations

2. Abnormal test results are received by a practice but are not acted upon, or are not considered for action.

Prescribing when known contraindications exist

3. Prescribing teratogenic drugs to a patient known to be pregnant.
4. Prescribing combined oral contraception after previous confirmed DVT/PE.
5. Prescribing oestrogen-only HRT for women with intact uterus.
6. Prescribing a drug to a patient that has previously caused them a severe reaction (and this has been correctly recorded).

Medication

7. Prescribing 'high risk' medication without ensuring adequate monitoring.
8. Giving the right drug via the wrong route or at the wrong site.
9. Prescribing Methotrexate daily rather than weekly (unless initiated by a specialist for a specific clinical condition such as leukaemia)
10. Prescribing aspirin for a patient under 12-years-old (unless for a specific condition such as Kawasaki's disease).

Medicolegal incidents

11. Physical assault of patients or healthcare workers.
12. 'Ignoring' a patient's living will.
13. A practice team member working while intoxicated.
14. Losing controlled drugs.

Clinical management

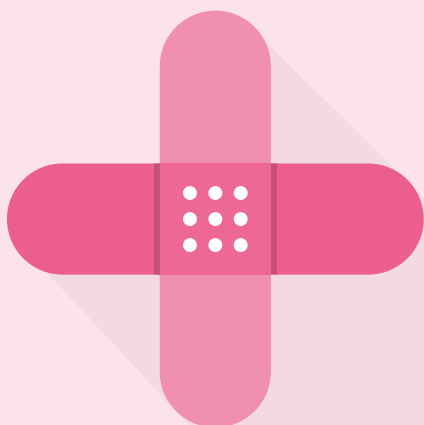
15. Not referring a patient presenting with, and treated for, anaphylaxis to secondary care for observation.
16. Not urgently referring a child suspected to have non-accidental injuries.
17. Performing a cervical smear without visualising the cervical os.

Systems

18. A practice does not have an up-to-date and secure backup of their data.
19. Medical waste and hazardous substances are discarded in an inappropriate manner.
20. Emergency medical equipment is not available, maintained, in working order or checked regularly
21. A needle-stick injury due to a failure to dispose of sharps in compliance with national guidance and regulations.

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CONSIDERATIONS WHEN VOLUNTEERING AS A SPORTS PHYSICIAN

Many doctors enjoy lending their medical expertise through volunteering. While it can be rewarding, Dr Sonya McCullough advises doctors to keep in mind that there are potential risks as well

READ THIS ARTICLE TO:



- ✓ Find out what you need to consider when undertaking a voluntary sports physician role.
- ✓ Learn about issues around conflicts of interest and confidentiality.
- ✓ Give consideration to your legal and indemnity requirements.



CASE STUDY

QUERY

I am an orthopaedic consultant surgeon working in Ireland and would like to extend my role to volunteer as a sports physician, where I am hoping to be taken on an honorary role as a doctor looking after the players in my local county GAA football team. Are there any pitfalls that I should be aware of?

ADVICE

We advise that you find out as much as possible about the role and the club's expectations of you. We would also request that you contact Medical Protection membership services and set out your proposed additional duties in writing to ensure that you are appropriately protected to carry out this volunteer role.

Even where your participation in managing the Gaelic football team at matches is voluntary, you should approach the role as you would with any paid employment and you would need to ensure that you meet the certification requirements for the sport.

We would also point you to your ethical obligations contained within the Guide to Professional Conduct and Ethics for Registered Medical Practitioners 8th Edition 2016.1 The following sections provide you with some useful information:

- Paragraph 14 – Emergency situations
- Paragraph 57 – Professional indemnity
- Paragraph 66 – Maintaining competence

While you have no official contractual obligation to the GAA club, we would strongly advise you to discuss the matter with the Irish Medical Organisation or seek independent legal employment advice should you have any concerns. It would be beyond the scope of Medical Protection's expertise to provide specific comment on contractual obligations or employment matters.

While Medical Protection would be unable to advise on the appropriate medical cover at any particular sporting event, we can advise in general terms on the expectations we would have of any individual doctor providing medical assistance at such events.

You should also ensure that your Medical Council registration is up-to-date. In addition, some semi-professional and amateur events may require further certification and training – you should check this with your local and county clubs.

CHECKLIST

1. You must ensure that all your skills are up-to-date and that you have the appropriate qualifications and specific expertise required for the role and the sport.
2. You should acquire a basic knowledge of the sport, its risks and the possible injuries participants may sustain.
3. You must ensure that you are familiar with the guidance of the sport's ruling body.
4. You should ensure that appropriate medical equipment for the sport is available according to the ruling body's requirements and professional opinion.
5. You should clarify whether the venue will provide appropriate equipment or whether you are expected to bring your own. It will be your responsibility to ensure that the equipment is in good working order regardless of who provides it.
6. You should be familiar with the local emergency services and any protocols that they have.
7. While you may be providing medical services to a semi-professional team or individual, you need to be aware that you may also need to provide first aid to spectators.
8. Please remember that you are expected to act within your area of competence and any serious matters may need to be referred to the local hospital's Accident & Emergency Department.
9. You should ensure that the level of your responsibility is agreed with the event organisers.
10. Should you be required to provide treatment to a member of the team, you should document your findings clearly and retain the record.
11. You may want to contact your Medical Faculty in respect of further training and advice.

OTHER CONSIDERATIONS

Using your medical skills to help out in the community, for example at a sports club, can be extremely gratifying, however doctors should ensure they consider the implications before getting involved.

CONFLICTS OF INTEREST

It is possible that you may face pressure, expectation and even criticism from club sponsors and agents, although less likely as a volunteer. You may find yourself pressurised by individual sports players for them to stay on the pitch or go back to their game earlier than you would recommend. In these circumstances the care of the patient is of paramount importance and there is a risk to the sports person if you do not have their best interest in mind at all times. There is also a risk to you as a doctor if you do not act with integrity and honesty. In circumstances where you were to treat sports people in the public spotlight, it is possible that you may receive media attention. In that regard, we would advise that you contact our Press Office should you have any concerns.

CONFIDENTIALITY

You must not disclose any medical information about your patients to the club (or anyone else) without their express consent. Confidentiality must be maintained at all times and you should not offer any comment to the press about the patient. In circumstances where you find yourself in a difficult situation with respect to confidentiality, please do not hesitate to contact Medical Protection for further advice.

FIND OUT MORE

For information about indemnity for additional duties such as a voluntary sports physician role, visit **[medicalprotection.org](https://www.medicalprotection.org)**

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MEDICATION ERRORS AND SAFER PRESCRIBING

Dr Diarmuid Quinlan discusses the rising tide of polypharmacy, and the danger of 'drug-drug' interactions

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READ THIS ARTICLE TO:



- ✓ Understand the potential pitfalls of polypharmacy.
- ✓ Learn which medications put patients at highest risk.
- ✓ Discover resources and techniques to implement safer prescribing.

Errors in prescribing are not only potentially lethal, but incredibly common; they account for approximately 20% of Medical Protection GP claims. The number of items prescribed in Ireland is enormous, and growing – we prescribed 74million items in 2013, up from 32million in 2000^{1,2}. The medication bill in Ireland was almost €2 billion in 2014, consuming 15% of the total health budget¹.

The number of patients on polypharmacy doubled between 1995 and 2010. Currently

22% of patients are on five or more medicines, and 5.8% are on ten or more². Polypharmacy is closely associated with old age, nursing home residents and deprivation².

ILLEGIBLE PRESCRIPTIONS

When trying to decipher an illegible handwritten prescription, stop and think; the liability for prescribing rests with the doctor who signs the prescription. If you erroneously transcribe an illegible prescription, it may cause serious patient harm.

Recognising the scale, complexity and gravity of medication errors, the IMC specifically addresses prescribing, stating: “the prescriptions you issue must be legible, dated, signed and must state your Medical Council registration number.”

Thankfully, most of our GP prescriptions are computer generated and printed, but when hand writing a prescription, ensure it is legible and consider printing the drug name in capital letters to avoid confusion. When prescribing in the out-of-hours service, it is especially important to ensure your prescriptions are fully compliant.



Medication errors are common, potentially lethal and a leading cause of patient litigation, and so the need for medicine optimisation, reconciliation and review is important

CHILDREN AND DRUG ERRORS

“Children are particularly susceptible to ...dosing errors”. Consider this recent audit in Ireland, which showed that the amoxicillin dose in children was wrong in 84% of cases³. All incorrect doses were sub-therapeutic, which can potentially cause a young patient to deteriorate and become seriously unwell. For more information, see the current Irish antibiotic guidelines at antibioticprescribing.ie⁴.

You may wish to undertake an audit of amoxicillin in children in your practice. A really useful antibiotic audit tool is available on the HSE website (hse.ie).

HIGH RISK MEDICINES

The IMC advises that prescriptions should be “safe, evidence-based and in the patient’s best interests”.

There are a small number of medicines which repeatedly cause a huge amount of patient harm. Methotrexate, Lithium and Sodium Valproate are medicines with a poor safety record in Ireland.

Methotrexate alone is responsible for 26% of all fatal medication errors⁵. You can read more about the safe use of methotrexate on the Medical Protection website. ICGP also has a user-friendly methotrexate audit proforma available, which you can find on its website (icgp.ie).

A report on Lithium showed a “poor standard of monitoring”, with only a third of patients meeting recommended blood test guidelines⁶. A separate, UK-based study reports lithium causing serious patient harm, including several deaths. It states: “in light of lithium’s potential for toxicity, there is an important potential for harm and/or

litigation if accepted procedures are not followed.”

The Irish Medication Safety Network has user-friendly ‘Best Practice Guidelines’⁷ for lithium, which you can view online (imsn.ie).

Sodium Valproate is highly teratogenic, causing “developmental problems, autism and malformations in children”, and therefore should not be used on “women of childbearing potential or pregnant women unless alternative treatments are ineffective”.

Despite these recommendations, Valproate is currently prescribed to 3/1000 women of childbearing age in Ireland, and recent evidence concludes that Valproate prescribing is increasing⁸. The HSE has several resources on prescribing Valproate (hse.ie).

PHARMACIST SUPPORT

Actively developing relationships with your local pharmacist is recommended; they have more extensive training in pharmacology and therapeutics than most doctors. Indeed, the IMC states that you should be particularly careful when “prescribing multiple medications in case the combination might cause adverse reactions, and you should liaise with the pharmacy to clarify any issues or concerns you may have.”⁹

Research shows that 3.7% of all hospital admissions are drug-related, and the majority are preventable¹⁰. Research in Irish general practice demonstrated that 12.4% of prescriptions contain an error¹¹, 2.4% of which are “potentially serious”¹¹.

TELEPHONE PRESCRIPTIONS

Many GPs are familiar with pharmacists phoning to clarify or amend a prescription, which plays an invaluable role in alerting GPs to errors, or potential errors. The IMC recommends that you should “make a note of the call in the patient’s records and send a written prescription to the pharmacist within 72 hours”.

MEDICATION REVIEW

Medication errors are common, potentially lethal and a leading cause of patient litigation, and so the need for medicine optimisation, reconciliation and review is important.

Medical Protection has a workshop with more detail on this, entitled Medication Errors and Safer Prescribing in General Practice. Please see the website to reserve your place, free as a benefit of membership.

PATIENT SAFETY AND THE FUTURE

The risks associated with medication error will continue to evolve, and become increasingly complex. The recent arrival of Novel Oral Anticoagulants (NOACs) heralds an entirely new class of high risk medications, with different indications, doses and risks¹². In line with guidance from the IMC, you should “keep up-to-date with developments in medication safety”.

CONCLUSION

We face a rising tide of polypharmacy and ‘drug-drug’ interactions with many medication errors in Irish prescriptions. Elderly patients, nursing home residents and people on multiple medicines are especially vulnerable to harm. Make your prescribing as safe as possible in our increasingly complex clinical world; with undeniable benefits for the patient, the practitioner and the pharmacist, safer prescribing can be a ‘win-win-win’ situation.

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PRESCRIBING ANTIDEPRESSANTS TO A MINOR

Dr Sonya McCullough discusses a case in which a GP considers the ethics of prescribing antidepressants to a minor



READ THIS ARTICLE TO:



- ✓ Be aware of the issues when considering prescribing antidepressants to minors.
- ✓ Consider the legal and ethical implications on prescriptions of this nature.
- ✓ Understand the importance of considering parental consent in this case study.

Dr T is a GP in a busy urban practice, where a 15-year-old girl attends regularly with a history of mild depression. There are issues in and around consent if Dr T were to prescribe her an antidepressant.

LEGAL OBLIGATIONS

Section 23 of the Non-Fatal Offences against the Person Act permits young people aged 16 and over to consent to surgical, medical or dental treatment without consent from their parent/guardian. The logical corollary to this is that children under 16 will require parental/guardian consent. This is indeed the case with the provision of mental health services to minors under the age of 16, where parental/guardian consent is required.

Minors aged between 16 and 18 who access mental health treatment on an out-patient basis through CAMHS (Child and Adolescent Mental Health Services), their GP or other counselling services, should be able to consent to treatment without parental/guardian consent. Furthermore, it appears that the 'mature minor' approach may be capable of applying to minors under the age of 16 accessing such services.

There is less clarity when it comes to in-patient treatment. An uncertain relationship between the provisions of the Mental Health Act 2001 and the Non-Fatal Offences against the Person Act 1997, has left a question mark over whether 16 and 17 year olds who are admitted for treatment under the 2001 Act can consent to treatment without parental/guardian consent. Therefore, the cautious approach is to consider that parental/guardian consent is required for the mental health treatment of a minor aged under 18 who is being treated for a mental disorder covered by the 2001 Mental Health Act.

Both parents may have the legal right to be involved in decision making regarding their child; however, there is debate as to whether consent of both parents is necessary. It can be argued, based on Article 41 of the Constitution and the Guardianship of Infants Act 1964, that the consent of both is required, and as such, if both parents have expressed a desire to be involved in decision making this must be facilitated as far as possible.

Clearly though, from a practical point of view, obtaining the consent of both parents can be difficult and may

cause delays. In such circumstances, the consent of one parent is often acceptable in practice. Proceeding on this basis presupposes that the minor's welfare is the paramount consideration, and that the proposed treatment or intervention is in the minor patient's best interests.

Even if there has been no indication of a desire to be involved by a parent/guardian, if the proposed treatment could have profound and irreversible consequences, both parents/guardians should be consulted if possible. In emergency situations, the overriding obligation is always to act in the patient's best interests.

In Dr T's case, as the child is 15, the provision of mental health treatment will require parental/guardian consent, subject to the possibility of Gillick style competency existing and being applicable. Dr T would need to be satisfied that the requisite maturity, insight and resolve of personal views are present on assessment of the patient.

Gillick competence is not recognised in Ireland, but the latest edition of the Medical Council's Ethical Guide and the HSE's National Consent Policy support its application, and the recent Constitutional Amendment following the Children's Referendum is in keeping with that approach.

Once the child turns 16 (if she continues to access treatment through CAMHS, her GP and/or counselling services) she should be capable of consenting to treatment without parental/guardian consent.

ETHICAL OBLIGATIONS

Paragraph 18.5 of the 8th edition of the Medical Council's Guide to Professional Conduct and Ethics (2016) provides guidance to practitioners in situations where a young person (generally considered to be a person under the age of consent) refuses to involve a parent or guardian.

Paragraph 18.7 advises practitioners that "you should provide treatment for young people without informing their parent(s) or guardian(s) if, having considered the factors in paragraph 18.5, you consider that it is in the patient's best interests to do so and the patient has sufficient maturity and understanding to make the decision".

Paragraph 18.8 provides that "children and young people have a right to confidential medical treatment as set out in paragraph 29. However, parents and guardians also have a legal right to access medical records of their children until they are 18. You should tell children and young people that you cannot give an absolute guarantee of confidentiality".

Where the patient is close to the age of being able to consent in her own right (ie at 16) it is strongly arguable that the 'mature minor' competency style approach applies dispensing with the requirement for parental/guardian consent.

Dr T would also be advised to carefully document all the interactions with the minor patient and/or her parent(s).



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