



# Practice MATTERS

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# WELCOME

**Dr James Lucas**  
Editor-in-chief



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

I'd like to start off by saying a particular "hello" to readers as this is my first edition as the new editor-in-chief of *Practice Matters Ireland*. I have worked at Medical Protection for nearly five years, as a medicolegal adviser focused on cases in Northern Ireland and the Republic of Ireland. I have a firm belief in the value of education in helping to keep members out of trouble, and am excited about further developing *Practice Matters Ireland* into a powerful resource that you can rely on. It's also a great honour to succeed my colleague Dr Sonya McCullough, who has spent many excellent years heading up the publication.

One legacy from Dr McCullough that I will be continuing with are the "ask the expert" and "from the advice line" sections, which are great ways to see Medical Protection advice and expertise in action...you can read my first contributions on pages 8 and 18 respectively. Elsewhere, we provide a recap on GDPR, which has been on everyone's minds for at least the past year – now it's in place, we remind you what steps you should have taken by now to ensure compliance, together with some practical tips on shoring up any outstanding issues.

We also look ahead at some upcoming offerings from Medical Protection. Our education team will soon be launching a complaints workshop for practices in Ireland, and Kate Taylor's comprehensive article on page 16 gives a preview of what these have to offer. On page 13, you can also get a taster of our general practice conference, which is coming to Dublin on 8 September.

I hope you enjoy this edition of *Practice Matters Ireland*. As ever, we are keen to hear what our members think, and we welcome any feedback, queries or suggestions that you may have.

**Dr James Lucas, Editor-in-Chief**





# STANDARD BEARERS

Healthcare standards across Irish primary care are being closely monitored more than ever before. We recently visited Mallow Primary Healthcare Centre (MPHC) in Cork, who have developed their own international primary care standards: **Dr David Molony**, GP, and **Damian Casey**, facilities manager, tell us more



**W**ith the Health Information and Quality Authority (HIQA) having legislative responsibility to enforce its *National Standards for Safer Better Healthcare*, there has probably never been a more pressing need to measure the quality of healthcare delivered to patients. HIQA's standards "are aimed at protecting patients and they provide, for the first time, a strategic approach to improving safety, quality and reliability in our health services".

## HOW DID THE INTERNATIONAL PRIMARY CARE STANDARD (IPCS) DEVELOP?

As managers of one of the first and biggest primary care centres in the country, we felt the need to demonstrate and measure patient care and standards in a comprehensive and recognisable manner. Having looked at systems around the world, MPHC was built in 2010 to the highest medical building standards that we could find.

But, at the time, we felt that there was a lack of an affordable, fit-for-purpose standard for managing primary care centres, GP practices and other primary healthcare businesses. With the co-operation of different individuals experienced in clinical, management and scientific standards development, as well as inputs from patient groups and an experienced auditor, we developed the IPCS over a six-year period.

The standard was presented at the BMJ International Forum for Quality & Safety in Healthcare in London, in April 2015. It has since been rolled out to other primary care centres and GP practices in the last few years. We recently released our new standalone standards management software and computerised auditing tool to help streamline the process, giving GPs and practice managers the tools they need to efficiently implement the standards and achieve certification.

## HOW CAN A PRIMARY CARE STANDARD HELP GP PRACTICES?

General practices and primary care facilities are businesses and need to be run efficiently and effectively, as with any business. Management standards need to be of the highest quality if the business is to succeed and provide resources for the delivery of patient care. Staff and patient risks have to be assessed regularly and acted upon, and every general practice is legally required to have an up-to-date practice safety statement. GPs now need to have audit systems built into their working environment to satisfy the Medical Council guidelines for registration. Standards are also expected by the public, state, colleagues and courts.

Standards provide staff with a sense of responsibility and understanding of their roles. They also provide them with sources of legislative, and other, information they require. Most importantly, they can be independently audited, which gives the confidence that the practice is ready for any future legislative audits and HIQA licensing.

From a management point of view, primary care standards provide management with a transparent review structure to oversee all the processes, review legislative requirements on an ongoing basis, and provide the structure to review key performance indicators (KPIs) in clinical, management and financial areas. Once in place, these should continue to benefit the practices and give early warnings of problems.

The standards and software can provide an invaluable tool for practice management tutorials for young doctors and new staff, taking the mystery out of practice management.



There is a cost in initially implementing standards and there is a cost involved in the certification process itself, but we expect that these costs will be recouped from increased efficiency, identification and elimination of waste, more efficient staff use, identification of responsibilities and organised review of patient care programmes.

### HOW DO PRIMARY CARE PROVIDERS/GP PRACTICES ACHIEVE CERTIFICATION TO IPCS?

There are three levels at which primary care facilities/practices are certified to IPCS:

**Level 1:** The primary care facility/practice fulfils all legislative requirements, ie, safety statement, risk assessments, Medical Council and legislative requirements.

**Level 2:** The primary care facility/practice has a high management standard and is monitoring their activities and processes with a continuous improvement programme.

**Level 3:** The primary care facility/practice has a commitment to the highest standards attainable, consults regularly with patient groups, measures and reviews clinical, management and financial key practice indicators and shows a high level of community involvement. This level addresses HIQA's *National Standards for Safer Better Healthcare*, as well as key elements of *International Management Standards ISO in Quality and Health Welfare and Safety*.

IPCS have developed a software package that has been designed for managing all standards-related documents and records required for audit and certification. Documents that are updated are automatically archived so that continuous improvements can be demonstrated to auditors.

This also ensures the most up-to-date documents are available to staff at point of use; for example, practice-specific safety statement and risk assessments, internal audits, needlestick policy etc. Core IPCS documents, as well as annual legislative registers, are automatically updated in the software.

Certification can be achieved by completing five two-hour training modules, in conjunction with installing and populating the IPCS software with practice-specific documents and records. Once the IPCS system is in place and records kept for six months, it can be audited externally by EQA Ireland, an independent, international accreditation body operating under the Irish National Accreditation Board. The purpose of an audit is to demonstrate compliance with policy, protocols, best practice, codes and legislation by seeking objective evidence.

Certification is maintained by annual audits, with the aim of implementing programmes of continuous improvements. Annual scores can be generated by the audit software and improvements tracked year on year.

## AT A GLANCE

### The international primary care standard (IPCS)

The IPCS defines the controls required to demonstrate compliance and best practice with the management standard for primary healthcare centres, GP practices and primary care providers.

It acknowledges and complies with the fundamental principles of the following international standards and best practice guidelines:

- ISO/OHSAS 18001:2007 Occupational Health and Safety Standard
- *National Hygiene Services Quality Review 2008*, HIQA
- *National Standards for Safer Better Healthcare 2012*, HIQA
- *Guidance on Information Governance for Health and Social Care Services in Ireland 2012*, HIQA
- *National Standards for the Prevention and Control of Healthcare Associated Infections 2008*, HIQA
- *Joint Commission International Accreditation Standards for Primary Healthcare Centres 2008*
- Health & Safety Authority Ireland
- Legislation, regulations and codes of practice.

### What primary care operations are covered by the standard?

IPCS covers the following areas:

- Definition and communication of the health and safety policy
- Clinical and operational risk assessment and controls throughout the organisation
- Compliance with legislation and codes of practice
- Transparent patient care pathway
- Formal complaints process
- Overview of patient, staff and public interactions
- Overview of financial management
- Continuous improvement programme
- Understanding of roles and assessment process
- Training plans and records for all practice staff
- Security for patients and staff
- Pathways to develop primary care
- Protection for all in transparent system
- Internal audits/management reviews, and external audits by EQA
- Maintenance and calibration of all practice equipment and critical building systems
- Management of all potential emergency situations (fire, accidents, spillages, pandemics, etc)
- Eventual integration of quality, environmental and safety systems
- Measurement of key performance indicators (KPIs) for chronic disease and multi-morbidity patients (both clinical and financial).

### What are the benefits of IPCS certification?

- Provides a continuous review and improvement processes, which are essential for quality and safety in healthcare
- Organisations are able to drive their own improvement processes
- Regulatory bodies: their role will be less demanding
- Effective, low cost, light but robust system of regulation
- Practice management tool that produces auditable records
- Financial return to the practice through effective KPI measurement
- Excellent tool for training young doctors and staff in practice management.

More information is available at [ipcs.ie](http://ipcs.ie) and you can also email [info@ipcs.ie](mailto:info@ipcs.ie)

# CASE STUDIES

## CARRAIG MEDICAL CENTRE, **TRALEE**

“The introduction of the international primary care standard is the single best development in my practice since I started in Tralee in 2001. By implementing the standards it has improved how I manage and run my practice, as well as protecting the health and safety of my patients and staff. I would recommend the introduction of the international primary care standard to any practice who wants to establish ongoing improvements in their practice.”

**Dr Michael McGrath**



## AYRFIELD MEDICAL PRACTICE, AYRFIELD PRIMARY CARE CENTRE, **KILKENNY**

“We adopted the international primary care standard when relocating our practice to our new primary care centre in 2012. We recognised the need to control and improve our health and safety performance, and put systems in place to manage the new building. It has provided us with a structured framework whereby we have improved our management systems throughout the practice. We now have systems in place that identify safety risks, reduce the potential for accidents and aid legal compliance. Our staff benefit from working in a safer environment and our patients appreciate our commitment to a best practice standard.”

**Ronan Kearney,**  
*general manager*

# ASK THE EXPERT

**Dr James Lucas**, medicolegal adviser at Medical Protection, answers some queries from members



**O**ne of our patients, diagnosed with a progressive neurological illness, has recently been made a ward of court. The patient's son, appointed by the court to manage his affairs, has asked the practice for information about his father's health. A GP from our practice has assessed the patient as lacking capacity to make a decision with regards to the disclosure. Is the patient's son entitled to access his father's confidential information?

The High Court judge making the wardship order normally makes a further order appointing a "committee of the ward". The committee (which, despite the name, is usually one person and often a family member) may be given certain powers to make decisions (generally in connection with the property and money of the ward).

The committee is expected to oversee the personal welfare of the ward from day to day. In addition, the registrar of the wards of court is entitled to require the committee to report at intervals on such issues as the ward's "residence, physical and mental condition, maintenance, comfort and such other matters in relation to the Ward as he may wish to be informed of".<sup>1</sup>

If the patient's son is seeking information as a committee member, it would be reasonable for the practice to disclose relevant medical information, thus allowing him to fulfil his legal obligations. This is consistent with the Medical Council's advice to doctors (see box 1).<sup>2</sup> In this instance, the practice should ask the patient's son to explain why the information is needed. The practice's justification for any disclosure should then be recorded in the medical records.

## BOX 1

**"If the patient lacks capacity to give consent and is unlikely to regain capacity, you should consider making a disclosure if it is in the patient's best interests."**

It is important to remember that the committee does not have unfettered rights of access to medical information pertaining to the patient (for example, historical information that is unrelated to the patient's current condition).

The law in relation to capacity is set for change. Once the Assisted Decision-Making (Capacity) Act 2015 is fully implemented, each ward of court will be reviewed in accordance with the new system. A ward who is found to have capacity will be discharged from wardship. A ward who continues to have capacity needs will be discharged from wardship and offered the support option most appropriate to his or her needs.<sup>3</sup>



We installed CCTV in our car park following a review of security arrangements. A patient has asked the practice for a copy of video footage, showing him parking his car and entering the building. The patient says that another driver is contesting an insurance claim and he requires the CCTV footage to show that his car was undamaged when he entered our car park. Are we obliged to facilitate his request?

The Data Protection Commissioner (DPC) explains that recognisable images captured by CCTV systems are “personal data” and, therefore, subject to the provisions of the data protection legislation.<sup>4</sup>

Any person whose image is recorded on a CCTV system has a right to seek, and be supplied with, a copy of their own personal data from the footage.

The patient in this instance should be asked to provide the practice with a reasonable indication of the timeframe of the recording being sought. It would not suffice for the patient to make a very general request, saying that they want a copy of all CCTV footage held on them.

For the practice’s part, the obligation in responding to the access request is to provide a copy of the requester’s personal information. The DPC explains that this normally involves providing a copy of the footage in video format. In circumstances where the footage is technically incapable of being copied to another device, or in other exceptional circumstances, it is acceptable to provide stills as an alternative to video footage. Where stills are supplied, it would be necessary to supply a still for every second of the recording in which the requester’s image appears, in order to comply with the obligation to supply a copy of all personal data held.

The DPC has also issued guidance that is relevant to practices dealing with requests for CCTV footage, which contain images of other parties (see box 2).

## BOX 2: IMAGES OF THIRD PARTIES

The onus lies on the practice to pixelate, or otherwise redact or darken out, the images of those other parties before supplying a copy of the footage or stills from the footage to the requestor. Alternatively, the practice may seek the consent of those other parties whose images appear in the footage to release an unedited copy containing their images to the requestor.

## LEARNING POINT

Where a data controller chooses to use a CCTV system to capture and record images of living individuals, they are obliged to shoulder the data protection obligations that the law places on them.

## REFERENCES

1. The Law reform Commission, *Consultation Paper on Law and the Elderly*, 2003.
2. Medical Council, *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*, 8th Edition (2016), paragraph 30.2.
3. Department of Justice and Equality, *Assisted Decision-Making (Capacity) Act 2015*: [www.justice.ie](http://www.justice.ie)
4. Data Protection Commissioner, *Data Protection and CCTV*



# GDPR

## – ARE WE THERE YET?

The new data protection regulations came into force on 25 May. Is your practice compliant? **Dr Rachel Birch**, medicolegal adviser at Medical Protection, has previously written about GDPR on the Medical Protection website, [medicalprotection.org](http://medicalprotection.org).

Here, Dr Birch is delighted to welcome a helpful recap on the main changes from **Dr Conor O'Shea**, a GP and member of the ICGP Data Protection Working Group

**T**he concepts of data privacy and protection did not begin on 25 May 2018, but the legislation has undergone a significant upgrade in the form of the General Data Protection Regulation (GDPR).

We await a new Data Privacy Act from the Irish government, and GPs are doing their best to keep up with this moving landscape. The aim of this article is to help GPs to assess if the necessary changes are being made in their practices.

To begin, we should remember two important points. Firstly, the principle that an individual's personal data should be respected and carefully managed is a reasonable one. It is what we would expect for ourselves or our families. Secondly, when we refer to data we mean all personal information, both in electronic and paper format. The workflows in a typical general practice are such that data breaches involving paper are as likely to occur as electronic mishaps.

### LET US CONSIDER WHAT HAS CHANGED UNDER GDPR:

- It is now necessary for practices to be able to demonstrate that they have data protection policies and procedures in place and that they are in compliance
- Privacy notices should be in place (waiting room, website) and policy documents should be available to patients
- All data breaches that result in a risk to an individual's rights must be notified to the Data Protection Commissioner without undue delay and within 72 hours
- There are potentially significantly increased penalties for non-compliance or breaches, and you may be sued by an individual.



## AVOIDING PROBLEMS

While this looks somewhat daunting, there are some sensible measures that GPs can put in place to avoid problems.

Examples of data protection policies and procedures can be found in a number of guideline documents. Although this is not the only reference available, for consistency this article will refer to the ICGP publication *Processing of Patient Personal Data: A Guideline for General Practitioners*, which was specifically written for Irish GPs. It will also be subject to regular review, particularly in the coming months as the interpretation of data protection regulations evolve.

The cornerstones of compliance are clear policies and good staff training. Training should include all staff – GPs, nurses and office – and a record of all training should be retained. There is no specifically recommended training, but consideration should be given to a practice meeting, reference reading material or online education. What may be most helpful is to discuss issues and queries as they arise, and to keep a record of these. Practice policies should be reviewed regularly, and informal discussion may be an appropriate form of ongoing training.

While all should be trained, it is a requirement for a practice to have a data controller. This may be the practice if it is a legal entity, or one or all of the GP principals. Nominating all GP principals in the practice to be joint data controllers may encourage shared responsibility, while at the same time nominating an individual GP or other practice member as a data protection lead. The data protection lead would be the person(s) responsible for the implementation of the practice policies. The full responsibilities of the data controller are laid out in Part 1, Section 2 of the ICGP guidelines.

There is also a role of Data Protection Officer (DPO) described in GDPR, which is required where processing of personal data is taking place on a large scale. The current ICGP position is that most general practices are not “large scale” (although the definition is vague) and, therefore, that the appointment of a DPO is not essential. According to ICGP guidelines, there may be a requirement to appoint a DPO in a large general practice or when a commercial organisation manages a number of different practices. Medical Protection will be looking at this aspect of the regulations in more detail over the coming months, and will update members when we have greater clarity.



A fundamental aim of practice data protection policies should be to prevent either wilful or accidental loss, destruction, alteration or unintended access to personal data. However, in the eventuality of a data breach occurring, it is essential that the practice should have clear documentation available.

## RECOMMENDED DOCUMENTS WOULD INCLUDE:

- Practice privacy statement
- Record of processing activities
- Data protection accountability log and training record
- Confidentiality agreements (staff, medical students)
- Data breach protocol and record
- Internet security policy.

Examples of most of these are to be found in the guidelines. It would be sensible to keep all relevant documents in a dedicated data protection folder, which would be readily available to access.

## AUDIT YOUR SECURITY

As well as preparing documentation, it is required under GDPR that regular information security audits are performed to ensure that patient data is secured appropriately. The audit would include reviewing all hardware and software in the practice network, virus and malware protection, areas of internet connectivity and data back-up. This is a technical challenge and likely to be beyond the capabilities of most GPs or their staff, and therefore will likely require GPs to commission an external expert. If GPs have hardware support, their suppliers who know their systems may be well placed to perform this audit. It is recommended that GPs who have not yet commissioned an initial audit should do so as soon as possible.





While technical security can be provided by experts, it is important that all members of the practice adopt sensible online behaviour to minimise the risk of cyber attacks. Accessing information from the web is now a part of clinical practice, but it would be recommended that only approved and recognised websites be visited, and for work-related activity only. Social media and shopping sites should not be visited from practice computers. Likewise email activity should be restricted to work-related, and staff should be shown how to avoid various malware. Healthmail is the free secure email available to all GPs/ practices that connects to the majority of health institutions and related agencies: it is likely that GDPR will lead to an increased use of Healthmail in the years ahead. The use of fax is not prohibited under GDPR but carries a higher risk to data security.

It is also important to remember that most general practices have an additional data protection role as small businesses. It is equally necessary that any other personal information such as staff files, employment details, bank accounts and other business information should be subject to appropriate levels of security.

### ATTENTION TO DETAIL

The successful implementation of data protection policies is likely to require attention to detail. It is not just about technical matters. Data breaches might occur if the wrong prescription, letter or result is issued to the wrong person. Leaving reports or letters in the wrong place, or computer screens unlocked and visible, could be simple causes of problems. Third party requests for information can also be challenging; however, the situations in which these occur tend to be repetitive, and are best addressed by a consistent policy.

Having understood the principles of data protection, GPs and practice staff should adopt safe procedures that minimise risk. In time it is hoped that these would not be intrusive; rather they will become standard practice or second nature. For unusual or challenging circumstances, a conservative approach is likely to be best, and if in doubt your medical defence organisation would be pleased to offer advice.

### REFERENCES

1. [www.icgp.ie/go/library/catalogue/item?spid=D8C5EEEB-09BE-547E-123BFA15AA569669](http://www.icgp.ie/go/library/catalogue/item?spid=D8C5EEEB-09BE-547E-123BFA15AA569669)
2. <http://gdprandyou.ie/organisations/>
3. <http://gdprandyou.ie/resources/>

## MEDICAL PROTECTION ADVICE

In summary, Dr Rachel Birch recommends that you:

1. **Familiarise yourself fully with the ICGP guidance<sup>1</sup> and ensure that you check it regularly in the coming months, as there may be changes once the GDPR is in force.**
2. **Review the Data Protection Commissioner (DPC) website dedicated to the GDPR.<sup>2</sup>**
3. **Follow the DPC's GDPR checklist for organisations.<sup>3</sup>**

Further information on the GDPR can be found in our factsheet, available at [medicalprotection.org](http://medicalprotection.org)



# DILEMMAS: TREATING CHILDREN AND YOUNG PEOPLE

**Dr Sonya McCullough**, medicolegal adviser at Medical Protection, looks at a complex dilemma from the Medical Protection case files

**M**edicolegal dilemmas can cover a range of scenarios, and the following will be discussed in more detail at the Medical Protection GP conference in Dublin on 8 September. Although it is based on real Medical Protection cases, facts have been altered to preserve confidentiality.

## THE CASE

Mr O contacted his surgery in some distress, asking to speak to GP Dr Y urgently. Dr Y took the call and Mr O explained that he needed Dr Y to provide contraception for his 15-year-old daughter, Miss O. Dr Y arranged an appointment for his daughter the next day, accompanied by her father. Dr Y was concerned about the potential ramifications of providing treatment to the patient in the circumstances, and contacted Medical Protection for advice.

## LEARNING POINT

Firstly, it is important to obtain an accurate sexual history from the patient. If possible, interview the patient alone, initially without her father.

Miss O told Dr Y that her boyfriend was 16. They had been together six months and started a sexual relationship one month previously. Her boyfriend went to her school and they were very happy together; they were both studying for the junior cert. She didn't drink, smoke or take drugs. This was her first sexual relationship.

## LEARNING POINT

It is important to document this information very carefully in the medical records and take time to explore the issues with your patient. Dr Y also noted that her father, a widower, had been left to bring up two young daughters alone.

Miss O was happy for Dr Y to call her father into the consultation. Dr Y explained that his daughter wanted to start the oral contraceptive pill and Mr O had consented to this.

## CAN YOU PROVIDE CONTRACEPTION TO A PATIENT AGED 15?

The Non-Fatal Offences Against the Person Act 1997 Section 23(1) states that a child becomes an adult for the purposes of consenting to medical, dental or surgical treatment at the age of 16 years. Under the Act, a child under 16 cannot consent to medical treatment.

However, the Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners 2016*<sup>1</sup> says that when the patient is under 16, the parent(s) or guardian(s) will usually be asked to give their consent to medical treatment on the patient's behalf.

In this case, Miss O consented to her father being involved, and he consented to the treatment and was aware of the situation. As a result, there didn't appear to be an issue with prescribing Mr O's daughter contraception, in the circumstances.

## REFERENCES

1. Paragraph 18



## NOTIFICATION REQUIREMENTS

However, did Dr Y have a duty to report to the Gardaí or TUSLA the fact that Miss O was under the legal age for engaging in sexual intercourse? These requirements are outlined in the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 (the “2012 Act”):

### • Mandatory reporting obligation

Section 2 of the 2012 Act provides for a mandatory reporting requirement to the Gardaí regarding knowledge of crimes committed against children. Section 2 states that a person is guilty of an offence if:

*“(a) he or she knows or believes that an offence, that is a Schedule 1 offence, has been committed by another person against a child, and*

*(b) he or she has information which he or she knows or believes might be of material assistance in securing the apprehension, prosecution or conviction of that other person for that offence and fails without reasonable excuse to disclose that information as soon as it is practicable to do so to a member of the Garda Síochána.”*

### • Defences

In the 2012 Act, there are three defences available to a GP:

- **Section 2(1)** – A GP would only be guilty if they failed “without reasonable excuse” to disclose such information.
- **Section 4(1)(a)** – If the child makes known his/her view that they do not wish for the matter to be disclosed to the Gardaí. However, there is a rebuttable presumption that a child

under the age of 14 does not have the capacity to form their own view. Therefore, a 15-year-old can form their own view regarding disclosure. In this case, Miss O was quite clear that she did not want any information to be disclosed to any third parties.

- **Section 4(8)** – If it is the view of a GP who is providing or has provided services to the child in question, that the information should not be disclosed. This can only be relied on where they are able to demonstrate that the decision not to disclose was reached in a manner that “continues to apply the standards of practice and care” that “can be reasonably expected” of a person working in such a position.

Further requirements are outlined in the Children First Act 2015 (the “2015” Act) and *Children First: National Guidance for the Protection and Welfare of Children* (2017):



## LEGISLATION

Section 14(1) and (2) of the 2015 Act states that “a mandated person, such as a GP, is required to make a report to TUSLA where they know, believe or have reasonable grounds to suspect, on the basis of information that they have received, acquired or become aware of in the course of their employment that a child has been, is being or is at risk of being harmed”. This also applies where the child believes that they have been, are being or are at risk of being harmed, and disclose this belief to the GP in the course of their employment.

Section 14(3) of this Act states that a mandated person, such as a GP, shall not be required to make a report to TUSLA where:

- The GP knows or believes that a child, who is aged 15 years or more but less than 17 years is engaged, in sexual activity, and the other party to the sexual activity concerned is not more than two years older than the child concerned

*In this case, Miss O was 15 and her boyfriend was 16.*

- The GP knows or believes that there is no material difference in capacity or maturity between the parties engaged in the sexual activity concerned, and the relationship between the parties engaged in the sexual activity concerned is not intimidatory or exploitative of either party

*Having taken a careful history, Dr Y was content that this was the case.*

- The GP is satisfied that the child has not been harmed, is being harmed or is at risk of being harmed

*Again, Dr Y was comfortable that this was the case here.*

- The child concerned has made known to the GP his or her view that the activity, or information relating to it, should not be disclosed to the Agency and the GP relied upon that view.

*Miss O was very clear that she wanted to continue in the relationship and wanted contraception, and was adamant that it should not be disclosed to TUSLA or the Gardaí.*



## NOTIFICATION REQUIREMENT TO TUSLA

The TUSLA guidelines focus on the legal obligations placed on mandated persons, including GPs, under the Children First Act 2015. The guidelines state that as a mandated person, under the legislation, GPs are required to report any knowledge, belief or reasonable suspicion that a child has been harmed, is being harmed, or is at risk of being harmed. The 2015 Act defines harm as assault, ill-treatment, neglect or sexual abuse, and covers single and multiple instances.

The guidelines state that if GPs are in doubt about whether their concern reaches the legal definition of harm for making a mandated report, TUSLA can provide advice in this regard. If a GP's concern does not reach the threshold for mandated reporting, but the GP has a “reasonable concern” about the welfare or protection of a child, they should report it to TUSLA under this guidance.

## RECOMMENDATION

In relation to the 2012 Act, if Dr Y had felt that Miss O had been sexually harmed then he should alert the Gardaí. However, Dr Y made the assessment that this was not the case.

With regard to the notification requirement under the 2015 Act, the patient was between 15-years-old and 17-years-old, and her boyfriend was of a similar age with no indication of a material difference of capacity or maturity or an exploitative relationship. So provided Dr Y was satisfied that Miss O was not being harmed, and Miss O indicated that the information should not be disclosed, Dr Y was under no obligation to report to TUSLA, as per s14 (3) of the 2015 Act.

In addition, Dr Y needed to consider whether or not the father himself posed a risk to the child in view of the request. Having taken a very detailed history from Miss O, this was not an issue.

## FIND OUT MORE

This dilemma and many others will be discussed at the Medical Protection GP conference in Dublin on 8 September. With talks covering mental health and capacity, professionalism, healthcare for an aging population, and dealing with burnout and stress, it's a great opportunity to find out how to tackle the critical issues of today.

Visit [medicalprotection.org](https://medicalprotection.org) to book your place.

# TAKING CONTROL: MANAGING COMPLAINTS IN GENERAL PRACTICE

With written complaints to the Medical Council on the rise, **Kate Taylor**, clinical risk and education manager at Medical Protection, looks at the common reasons for complaints – and how you can manage them

**I**n everyday life we are prone to complaining. We complain about the weather, the traffic, the news, our health... sometimes we even complain about healthcare provision, including our GPs. According to the Medical Council, written complaints from patients are on the rise – from 308 in 2015 to 369 in 2016.<sup>1</sup>

## WHY DO PATIENTS COMPLAIN?

When patients' expectations are not met, they are more likely to voice a complaint. The most common reason for complaints is poor communication; however, patients often complain about their clinical treatment, staff attitude and the practice systems and processes, such as appointment availability, prescription issues, waiting times and delay in referral.

Complaints can be made in various ways:

- Practices could receive a verbal complaint directly to a member of practice staff
- A written complaint to the practice
- A formal complaint made directly to the Medical Council or Nursing and Midwifery Board of Ireland.

We know from the Medical Council that patients most commonly want the clinician to realise what they have done: they don't want the same thing to happen to another patient and they want to understand why the event occurred in the first place.<sup>2</sup>

The importance of an apology mustn't be underestimated in the context of a complaint; over half of patients who complain to the Medical Council simply want an apology.

If we were to bump into a stranger in the supermarket or busy street, we would offer an apology: patients are far more understanding if they are kept informed, so offering an apology if you're running late with your appointments or have to interrupt a patient to take an urgent phone call, or when something has gone wrong with the care of the patient, would go a long way to avoid a formal complaint.

Most people don't find it easy to apologise: they don't like to admit they were wrong. Another reason for not apologising is the fear of litigation. It is important to recognise that an apology is not acceptance of liability; however, it does acknowledge the thoughts and feelings of the patient, which can help in resolving the situation.

Complaints should also be viewed as a source of feedback, giving an opportunity to learn from what has not gone well, while also improving customer service.

## HOW DOES A COMPLAINT IMPACT ON GENERAL PRACTICE TEAMS?

Receiving a formal complaint can be extremely unpleasant for the clinician or practice team involved. Complaints can often be interpreted as an accusation of personal failure or a personal attack: we can feel that we have been personally criticised if someone complains about the care or treatment we have delivered. We mustn't underestimate the impact that this can have on individuals, as often formal written complaints can take several months to be resolved.

We often get a subtle indication when patients are unhappy with the care or service that they have received. This is the ideal opportunity to try and deal with it promptly, de-escalating the situation and avoiding it from progressing to anything more formal. Complaints are a source of frustration for the patient and their families too, so an early resolution would be a preferred option.

## COMPLAINTS PROTOCOL

Practices should have an in-house complaints procedure that clearly outlines their approach to managing complaints. Having a clear complaints procedure that patients are fully aware of will allow practices to take more ownership of complaints and, hopefully, negate the need for patients to go directly to the Medical Council or Nursing and Midwifery Board of Ireland. The practice should consider advertising this to patients via their website and practice leaflet, and in the patient waiting room.

The protocol should also outline timescales for investigation and formal response.



## COMPLAINTS MANAGER

Appoint a dedicated complaints manager. Having someone dedicated to take ownership and co-ordinate complaints is vital. This is normally the practice manager, supported by a senior GP partner. The role of the complaints manager is to co-ordinate the investigation, collate an appropriate response and feed back to the complainant.

## STAFF TRAINING

Practices must ensure that all staff has been trained in the complaints procedures; this could also be incorporated into the induction programme for new staff. This assists staff in managing any situations that could eventually result in a complaint, such as a verbal complaint at the front reception desk, which could be well managed by trained reception staff.

## PATIENT INVOLVEMENT

Depending on the nature of the complaint, it may be appropriate to offer to meet with the patient face to face to discuss the complaint. This offers a commitment to taking the complaint seriously, and that a full investigation will be undertaken.

## INVESTIGATING THE COMPLAINT

Investigations should be undertaken in a timely manner, so the situation does not escalate. Even relatively minor complaints justify being investigated; asking important key questions can help establish the facts:

- What actually happened?
- How did it come to happen?
- What can be learned from the event to reduce the chances of it happening again?
- What should have happened?

## RESPONDING TO COMPLAINTS

Following the investigation, it is important that the practice feeds back to both the complainant and practice staff as appropriate. Providing the patient with a written apology, a summary of the main issues as well as any action taken as a result of the investigation findings, constitutes a good complaints response.

It is also crucial to inform all practice staff of any improvements/ changes within the practice. It won't always be appropriate to advise all staff of every complaint, but informing staff of any required changes will go some way to preventing a similar complaint being received.

## CONCLUSION

Complaints are inevitable in general practice. However, how practices choose to respond and react to complaints can have an impact on early resolution – and can help to rebuild trust with patients and their families.

## AND THERE'S MORE

Medical Protection is launching a complaints handling workshop in Ireland – more details coming to [medicalprotection.org](http://medicalprotection.org) soon.

## REFERENCES

1. Medical Council Annual Report, 2016
2. Medical Council, *Listening to complaints: Learning for good professional practice* (2008-2012)



# FROM THE ADVICE LINE

**Dr James Lucas**, medicolegal adviser at Medical Protection, handles a call involving a prescription generated in secondary care



**M**rs V, a practice manager, contacted the Medical Protection telephone advice line to seek guidance on the practice's responsibilities when transcribing hospital prescriptions to General Medical Services (GMS) prescriptions.

Mrs V wished to clarify, in particular, the extent to which the GPs at the practice could rely upon the prescribing recommendations of colleagues in secondary care, when issuing such prescriptions.

## EXPERT ADVICE

Mrs V spoke to Dr P, an expert medicolegal adviser with a background in general practice, who also had a specialist interest in prescribing issues.

Dr P summarised the position with reference to the HSE's handbook,<sup>1</sup> noting that eligible patients who are provided with a prescription form on their discharge from hospital are required to request a GP, participating in the GMS scheme, to transcribe the prescribed items onto a GMS prescription form, in order for such items to be dispensed free of charge.

Dr P advised that there was a well-recognised risk of medication errors during the transition from secondary to primary care. He referred to an ICGP report on repeat prescribing, which noted that externally generated prescriptions, such as hospital prescriptions, require special attention given that they often get transferred into the repeat prescribing system without a face to face consultation.<sup>2</sup>

Dr P advised that the doctor signing the GMS prescription bore ultimate responsibility for it. This meant, for example, that in those cases where the dosages on the hospital prescription were illegible, the GP would need to consider contacting the issuing practitioner or service to confirm the correct prescription.

Dr P explained that the overarching medicolegal principle of prescribing was neatly summarised in the Medical Council's guidelines: "[A]s far as possible, you should make sure that any treatment, medication or therapy prescribed for a patient is safe, evidence-based and in the patient's best interests..."<sup>3</sup>

He went on to explain that transcribing a hospital prescription onto a GMS prescription was, essentially, prescribing at the recommendation of another healthcare professional. Dr P noted that the Medical Council had not made specific reference to the issue in its guidelines. However, prescribers could maximise patient safety by ensuring that the prescription was needed, appropriate for the patient and within the limits of their competence to prescribe.

Dr P followed up Mrs V's enquiry, in writing, with some clinical vignettes to illustrate safe approaches to prescribing in these circumstances (see box 1).

## BOX 1

### IS THE PRESCRIPTION NEEDED?

A young female patient was admitted to hospital with appendicitis. Following discharge, a relative presented a hospital prescription form to the patient's GP. The GP noted that a number of cardiac medications were included on the hospital prescription form. This was unusual because the patient did not have a history of cardiac disease. The GP did not issue a GMS prescription, but instead contacted the hospital ward to make enquiries. It soon became apparent that there had been an administrative error at the hospital and the medications listed on the form related to another patient.

### IS THE PRESCRIPTION APPROPRIATE?

An elderly male patient was diagnosed as having shingles following presentation to the Emergency Department (ED) with a rash and altered sensation. When recommending treatment with aciclovir, the ED physician had forgotten to consider the patient's history of renal impairment. Hence, the dosage recommended by the ED physician was excessive in the circumstances. The GP, when presented with the hospital prescription form, noted that the patient in question was undergoing long-term renal dialysis and was concerned about the recommended dosage of aciclovir (and, in particular, the increased risk of neurological toxicity). The GP checked a prescribing formulary and issued a prescription for a reduced dosage of aciclovir. The GP also contacted the ED to highlight the case for future learning.

## REFERENCES

1. HSE, PCRS handbook for doctors (*Information and Administrative Arrangements for General Practitioners*), 2006
2. Bradley C, *Repeat prescribing quick reference guide*, ICGP Quality in Practice Committee, 2013
3. Medical Council, *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*, 8th Edition (2016), paragraph 42.5



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