



Practice MATTERS

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NOTICEBOARD

WELCOME



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

With prescribing such a core component of general practice, it should perhaps be expected that such a frequently-performed process is also a major source of complaints and litigation. In this edition, we go over some basic – but commonly overlooked – risks and advise you on staying safe and avoiding medication errors. Our article “Prescription for safety”, on page 10, also looks at two medications in particular where extra scrutiny may be required: both valproate and amoxicillin have been subject to fairly recent changes in guidance and risk profile.

On page 6 we have an inspiring case study from Oakpark Medical Centre in Tralee, who substantially tackled their areas of risk after undergoing one of our clinical risk self-assessments, which are free to Medical Protection members as a benefit of membership. With the growing possibility of HIQA starting to inspect general practices across Ireland, it is as good a time as any to make sure you are safe and secure.

Elsewhere we look at a dilemma from our advice line, where a patient has asked to record a consultation, and provide some insight into a useful new safety tool launched by Medical Protection, based around the rigorous use of checklists. And with changes to data protection looming next year, make sure you read our important update on how this affects you.

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 Sonya McCullough
Editor-in-Chief

NEW LAW MEANS YOU MUST HAVE INDEMNITY

The Medical Practitioners (Amendment) Act has now come into force, making it a statutory requirement that all registered medical practitioners have adequate indemnity in place.

Fortunately, as Medical Protection members your indemnity arrangements already comply with the new Act. However, please note:

- New applicants to the Medical Council must provide evidence of professional medical indemnity on application. Doctors will not be placed on the register unless this evidence is provided.
- Doctors currently registered with the Medical Council will be asked to confirm their professional indemnity arrangements at the renewal of their registration in June 2018, and further communication will be issued closer to that time.

It is also worth noting that Medical Protection does not put a financial limit on the indemnity, unlike indemnity products offered by other providers and the Clinical Indemnity Scheme.

MANAGE DIABETES THROUGH YOUR GP – NEW RESEARCH


New research has found a significant improvement in the health of diabetes sufferers whose condition was managed through regular GP visits.

An audit of the Midland Diabetes Structured Care Programme, involving almost 4,000 patients over 15 years, found that medical complications from type 2 diabetes were reduced by over 80%. The audit was launched by Minister for Health Simon Harris.

It also found major savings can be achieved in the management of diabetes by general practitioners.

Dr Velma Harkins, GP lead for the study, said: “The results have been very encouraging. We saw an 80% reduction in eye, kidney and feet complications in patients with type 2 diabetes, and a 94% reduction in heart-related complications between 2003 and 2016.

“We also held patients’ BMI stable. The programme serves as an example of what can be achieved through proactive primary care-led management instead of episodic unstructured care. This approach delivers real results.”



There are over 200,000 people with diabetes in Ireland, and Dr Harkins estimated the cost of running the programme nationally at about €5 million a year. Minister Harris said he would like to see the diabetes programme rolled out throughout the country.

But he said that to do so, a new GP contract has to be put in place.

Mr Harris said the results of the regional programme were “compelling” and he would like to see it extended very quickly. But he did not wish to put a timeframe on it, given there are contract talks with GPs.

STUDY MEASURES IMPACT OF GP TEXT MESSAGING

A new study, funded by the ICGP, has looked at the use of text messaging across general practice. It aims to assess the extent, growth, and perceived risks and benefits of text messaging by GPs to communicate with patients, and assess patients’ attitudes towards receiving text messages from their GP.

The study, published in the *British Journal of General Practice*, used surveys, a review and a focus group, and was conducted in both urban and rural practices in the south-west of Ireland.

A telephone survey of 389 GPs was conducted to ascertain the prevalence of text messaging. Subsequently, the following were also carried out: additional telephone surveys with 25 GPs who use text messaging and 26 GPs who do not, a written satisfaction survey given to 78 patients, a review of the electronic information systems of five practices, and a focus group with six GPs to ascertain attitudes towards text messaging.

The study is available at bjgp.org/

One of the study’s authors, Dr Diarmuid Quinlan, is a GP in Cork and works as a Medical Protection educational presenter. For his work on this study, Dr Quinlan was awarded the Slaney Prize 2017 by the Republic of Ireland faculty of the RCGP. The rest of the study team are Dr Matt Dahm, Dr Dorothy Leahy (PhD) and Dr Aoife Lyons.

ICGP DISAPPOINTED BY BUDGET

The Irish College of General Practitioners (ICGP) has expressed disappointment in the Budget for 2018, saying that the failure to provide resources for a new GP contract will have a detrimental impact on those on lower incomes, and increase pressure on the acute hospital sector.

The ICGP has welcomed the small reduction in prescription charges, and the use of progressive taxation on tobacco and alcohol.

“GPs are acutely concerned at an absence of substantial provision for a new contract for general practice in the Budget, or specific reference to reversal of FEMPI cuts, which reduced practice income by over 30% in many areas,” said Dr Mark Murphy, Chair of Communications with the ICGP.

“Much has been done to ameliorate cuts to public sector wages and staffing as the Irish economy works its way out of recession, but GPs and their practice teams operate in the private independent contractor sector, and have had absolutely no reversals of cuts,” Dr Murphy added.

“A national manpower crisis looms, and to attract more doctors to become GPs, the Government must offer greater financial security and a new contract with flexible conditions and an expanded role in managing chronic diseases,” Dr Murphy said.



HOW DO YOU MEASURE UP?

As a standard, you should be ensuring your patients receive safe, quality healthcare, and it has been long expected that HIQA will eventually inspect general practices in Ireland. *Diane Baylis and Suzanne Creed*, clinical risk and education managers at Medical Protection, advise on ensuring you measure up

READ THIS ARTICLE TO:



- ✓ Understand the importance of risk-proofing your practice
- ✓ Find out how Medical Protection's CRSA can help

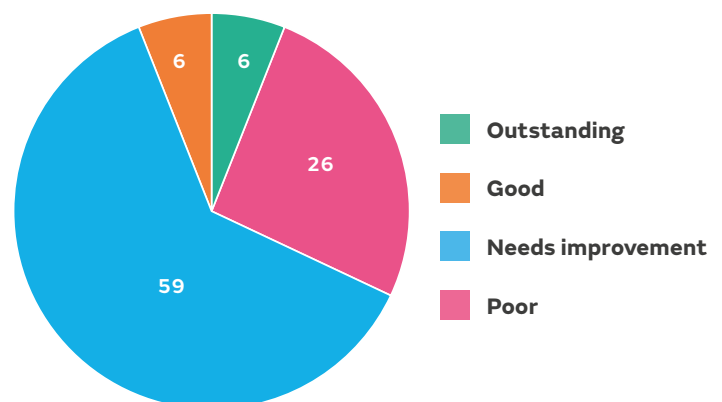
If the Health Information and Quality Authority (HIQA) started to inspect general practices in Ireland, how confident would you feel about the outcome?

At Medical Protection's recent GP conference, in Dublin on 16 September, Julie Price, head of risk management and education consultancy, posed this question to the audience of GP and practice manager delegates:

"If HIQA inspected your practice today, how would they rate your practice in terms of quality and safety of care? Would you be rated:

- Outstanding
- Good
- Needs improvement
- Poor?"

Ninety-seven delegates responded using an electronic voting system. Interestingly, the results illustrated that the majority of the audience felt they were in need of improvement:



Clearly, 67% of delegates at the conference felt that they had room for improvement. All healthcare providers have a responsibility to ensure the safety of patients and staff, ie, undertake risk management, regardless of an inspection.





Systems aren't sexy, but they save lives.

Harvard Medical School Professor
Atul Gawande⁴

WHERE TO START

To begin with, there are a set of standards that you need to be aware of. These are the National Standards for Safer, Better Healthcare (National Standards), produced by HIQA.¹ These National Standards apply to all healthcare services – excluding mental health – that are provided or funded by the HSE, including, but not limited to: hospital care, ambulance services, community care, primary care and general practice.

HIQA state that: “It is hoped that private healthcare providers adopt these National Standards voluntarily in advance of proposed statutory licensing.”

The quality and safety of care provision is now a major concern for all health systems: attaining a high level of safety is an essential step in improving the quality of care.² As a result, many countries have developed healthcare standards, so it is a positive step to have national standards identified.

In healthcare, when an error occurs, it is often due to system failure.³ It is important to make sure that you have robust systems in place to help you to:

- maintain standards
- provide consistency
- focus on patient safety in order to reduce avoidable harm to patients.

ASSESSING YOUR CLINICAL RISK

Systems are particularly important in the current climate of uncertainty and pressures facing general practice, specifically with unprecedented financial challenges and rising service demand.⁵ It is now widely accepted that, in healthcare, many patient safety incidents are potentially preventable⁶ and, for these reasons, much of our risk management activity is focused on improving systems within general practice.

One of the ways that Medical Protection can assist you to do this is through our Clinical Risk Self Assessment (CRSA) programme. Clinical Risk Self Assessments for General Practice is a systematic approach that identifies risk and develops practical solutions. It offers an opportunity for all members of the team – GPs, managers, nurses, receptionists and therapists – to work together, talk openly and develop practical solutions that promote safer practice.

CASE STUDY: OAKPARK MEDICAL CENTRE, TRALEE, CO KERRY

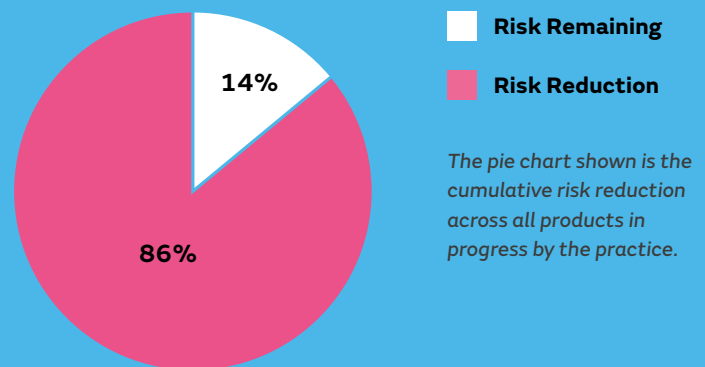
Oakpark Medical Centre in Tralee, Co Kerry, underwent a CRSA in September 2016 – here's what they have achieved since then.

Oakpark Medical Centre, a training practice, is located in the town of Tralee and offers a variety of ancillary services. The practice team consists of four GPs, a GP registrar, two practice nurses, a dietician, physiotherapist, psychotherapist, audiologist, optometrist and six secretaries.

Since their CRSA, at the time of writing this article they had reduced their identified risks by 86%. Well done to all involved!

Dr Joe Arthurs, senior partner at the practice, spoke to *Practice Matters Ireland* about the experience of having a CRSA, and how they have reduced their practice risk.

RISKS REDUCTION PROCESS



WHY DID YOU DECIDE TO HAVE A CRSA AT YOUR PRACTICE?

“I have always been aware of the increasing requirement to demonstrate standards in practice, through my work in the ICGP with the HIQA standards working group.

“In the course of my work with this group I became increasingly aware of the need to create an ongoing learning/awareness approach to standards. Standards need to be in evidence in practice. So when I became aware of the Medical Protection clinical risk self-assessment, I was immediately drawn to it – to invite a professional organisation into the practice to comment on how we were actually doing.”

WHAT DID THE DAY INVOLVE?

“This event was preceded by an extensive pre-visit questionnaire to all staff using a secure online survey. The content of all the returned questionnaires contributed greatly to the recognition of ‘blind spots’ within the practice.

“The CRSA itself involved a full-day visit from a specially trained clinical risk assessment facilitator, confidential exploratory discussions with key members of staff, followed by an afternoon multidisciplinary workshop that afforded staff the opportunity to discuss the findings and suggest solutions to risks identified.”



HOW DID YOU IMPLEMENT THE RECOMMENDATIONS FROM THE REPORT?

"We held several practice meetings and together all staff members went through each recommendation, making an action plan where possible. The online system lent itself to this and it continues to function as a checklist every few months, thereby keeping the process alive."

HOW DID YOU FIND THE ONLINE SYSTEM?

"On completion of the CRSA, we received a confidential report outlining the findings, actions to be taken, useful references and feedback from the patient safety staff survey using a secure Medical Protection risk management online system. The online system provided us with the capacity to log post-visit actions, enabling the practice to record the steps they've taken to mitigate their risks after the CRSA."

"The online system is an excellent communication/feedback tool. It was ideal for group work involving admin, nursing staff and GPs."

WHAT WERE THE 'BIG WINS' FOR YOU AND YOUR TEAM AT THE PRACTICE, HAVING HAD A CRSA?

"The big win is increased awareness of risk areas and the presence now in our practice of a 'drop-in shop' – the online system – which we regularly visit to remind ourselves of ever-present pitfalls. We have initiated many worthwhile patient safety changes within the practice as a result of the CRSA, in particular allocating a generous time slot for repeat prescription requests."

"The issues with poorly written hospital discharge letters and scripts is ongoing. We are now formally bringing this to the attention of the hospitals, thus reducing the risk of harm to our patients."

WOULD YOU RECOMMEND A CRSA TO YOUR GP COLLEAGUES?

"I would strongly recommend the CRSA for any practice as a quality initiative to improve standards in practice, and address a significant proportion of the HIQA agenda."

BENEFITS OF HAVING A CRSA FOR YOUR PRACTICE

Creating a safe environment for patients and staff is very important and, by implementing simple risk management principles, practices can address the risks that may compromise staff and patient safety.

There are many benefits of undergoing a CRSA. They can:

- improve practice systems and quality of care provided
- be useful for CPD
- help accumulate credit points for 'internal CPD' through the ICGP professional competence scheme
- reduce the likelihood of complaints and claims
- improve communication within the team
- identify non-compliance with National Standards
- provide recommendations of useful references and resources.

If you are interested in commissioning a CRSA for your practice, please contact us on **+44 (0)113 241 0359** or email crsa@medicalprotection.org

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FROM THE



ADVICE LINE

Dr Rachel Birch shares a recent case, where a member asked for advice on how to deal with a request from a patient to record his consultations



Miss T, a practice manager, telephoned the Medical Protection medicolegal advice line to seek advice on an unusual situation. Mr D was a new patient of the practice. He had seen Dr F twice with symptoms of anxiety and depression and had been signed off from his work as a teacher.

A few days after his second consultation, he telephoned Miss T and told her that he wanted to record his future consultations with Dr F. When she asked him why he wanted to do this, he became defensive and told her it was his “right” to do this.

She explained that she would have to discuss this with Dr F and get back to him. He suggested that if Dr F didn’t agree, he would record the consultations secretly on his mobile phone.

The request was discussed at a practice meeting, but opinion was divided on whether to allow Mr D to record consultations. It was therefore suggested that Miss T seek further advice from Medical Protection.

EXPERT ADVICE

Miss T called Medical Protection and spoke to Dr M, an expert medicolegal adviser who had worked for many years as a GP, and had also studied for additional law qualifications.

Dr M advised it would be prudent for Dr F to agree to Mr D recording his consultations. She suggested that otherwise, Mr D may record them covertly, and it would be better for doctor and patient to be honest with each other. Dr M also recommended that Dr F should not refuse to consult with Mr D, as he has a duty of care to Mr D and would be criticised if subsequent harm came to Mr D.

She advised that if Dr F felt uncomfortable with the request, he may wish to discuss his discomfort with Mr D and explore further Mr D’s reasons for the request. It could have been that Mr D’s current mental health symptoms were affecting his memory and that recording the consultations could be helpful to him. Dr F should also advise Mr D that the recordings should be for personal use only.

Finally, Dr M also suggested that if Mr D records his consultations, Dr F should ask for copies of each recording, so that they can be placed in Mr D’s notes to form a permanent record of what was discussed.

The Medical Council advises, in paragraph 34 of the *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*, that “audio, visual, or photographic recordings of a patient, or a relative of a patient, in which that person is identifiable should only be made with their express consent. You should keep these recordings confidential as part of the patient’s record. You should be aware of security when sharing information by electronic means, including text, other electronic messaging or emailing and you should do all you reasonably can to protect confidentiality”.

LEARNING POINTS

- Legally, there is a strong argument to suggest that patients do not need to seek a clinician’s consent before recording a consultation, because they are primarily processing their own personal information.
- It is likely that technological advances and the ability to record easily with mobile devices will lead to increasing requests from patients to record consultations.
- Patients may wish to record consultations so that they can replay them and remind themselves of what was discussed, rather than trying to take notes or bringing a friend or relative with them.
- The Medical Council advises: “You must give patients enough information, in a way that they can understand, to enable them to exercise their right to make informed decisions about their care” and “You should try to meet patients’ communication needs.”¹
- The recording of consultations may be advantageous to clinicians too, as it is likely to be more complete than a written clinical note and could therefore provide helpful evidence if the account of events is disputed.
- Clinicians acting ethically and professionally should have no reason to be concerned about being recorded in consultations. It is possible that in many years’ time, the recording of consultations, with copies held by doctor and patient, will be commonplace.

To contact Medical Protection with your own query, please call our medicolegal helpline on +44 113 241 0200

REFERENCE

1. Medical Council, *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*, 8th Edition (2016), paragraph 11

PRESCRIPTION FOR SAFETY

Medication errors are a substantial cause of litigation in Irish general practice. *Dr Diarmuid Quinlan*, a GP in Cork and member of Medical Protection's education faculty, looks at the scale of the problem and advises on best practice

READ THIS ARTICLE TO:



- ✓ Learn how to avoid medication errors
- ✓ Understand the risks of prescribing certain drugs

Medication errors comprise one fifth of all errors in Irish general practice, according to Medical Protection data. In this article you'll discover how to reduce the likelihood of common risks in prescribing medications. One of these risks, staying abreast of medications guidance, is explored further in relation to two medications:

- the safe and effective use of valproate in women of reproductive years, to minimise teratogenic side effects
- the amoxicillin dosage in young children, which changed in 2014, with substantial dose increases.



SAFE PRESCRIBING – THE BASICS

There are basic rules to follow when prescribing, which in essence may appear obvious:

- decisions should be made in the best interest of the patient
- you should avoid prescribing for yourself, friends or family
- you should stay familiar with the current guidance from the Irish Medicines Board.

The final point is particularly hazardous, because the potential consequences of non-compliance are extreme harm to the patient, or even death. Medications to pay close attention to include:

- NSAIDS
- benzodiazepines
- oral/topical steroids
- oral contraception
- anti-depressants
- opiates.

The following are potentially toxic:

- methotrexate
- lithium
- azathioprine
- warfarin.

When you sign a prescription, you are accountable for any complications that follow, so take care to follow a simple checklist:

- **check the dose, strength, frequency and route**
- **look for any allergies, interactions with any other current medications, or concurrent illnesses**
- **ensure you have the patient's informed consent on any agreed route of treatment, and monitor signs of improvement or side effects through regular reviews**
- **when repeat prescribing, it is good practice for prescriptions to be signed by a regular doctor, with time set aside to properly check the patient records: it is advisable to keep repeat and acute prescribing separate.**

THE OFFICIAL GUIDANCE

The Medical Council's *Guide to Professional Conduct and Ethics (8th Edition)* emphasises the importance of staying up-to-date on the benefits and risks of medications:

"You should weigh up the potential benefits with the risks of adverse effects and interactions when deciding what to prescribe. You should review patients' treatment regimes periodically.

"You should keep up-to-date with developments in medication safety. You should seek independent, evidence-based sources of information on the benefits and risks associated with medicines before prescribing." (paragraphs 42.5 – 42.6)

NEW RISKS

Two notable examples of recent shifts in medication risks are valproate and amoxicillin. In 2014, the European Medicines Agency strengthened its warnings (see www.migraine.ie) on the use of valproate in women and girls, due to the increased risk of developmental problems, autism and malformations in children exposed to valproate in the womb.

An audit of three Irish GP training practices between 2014 and 2015 found that almost 98% of amoxicillin prescriptions for children aged 5-12 years in GP training practices were wrong.¹ The recommended dose of amoxicillin in children changed in 2014, for the first time since the 1960s. Many clinicians were unaware of what was a substantial increase in the recommended amoxicillin dose.

In both cases, as with other risky medications, the standard rules for safe prescribing should be followed. Benefits and risks should be carefully reconsidered at regular treatment reviews. It may be a decade or more before harm emerges, and accurate, detailed, contemporaneous medical records are crucial.

A thorough informed consent process should be observed with the patient. Provide the patient with as much relevant information as possible. An example for valproate is an excellent patient information booklet from the HSE, which should be shared with the patient, and clearly documented in the medical record.

A further resource is the *Antibiotic Prescribing in Primary Care* guidelines, which were published by the HSE in the summer of 2016. This website helps GPs to optimise the 3Ds: correct **D**rug, **D**ose and **D**uration of antibiotic. There is an excellent antibiotic audit tool at the end of these guidelines.



FURTHER SUPPORT FOR YOU

Medical Protection has a three-hour workshop, developed for and delivered by GPs and free as a benefit of membership: Medication Errors and Safer Prescribing. Further details are available at www.medicalprotection.org/ireland/education-and-events.



This workshop provided me with numerous tips and strategies, enhancing the quality and safety of my prescribing. I strongly encourage you to attend.

REFERENCES

1. An Audit of Paediatric Prescribing of Amoxicillin, *IMJ* <http://imj.ie/2081-2/>

DATA PROTECTION IS CHANGING



Data protection law is changing next year. *Dr Rachel Birch*, medicolegal adviser, outlines what practices can do now to prepare themselves for this change

On 25 May 2018, the EU General Data Protection Regulation (GDPR) will come into force and will have a direct effect in every European country. It will supersede the existing data protection framework under the EU Data Protection Directive. It has been written to reflect the increasingly digital world and will allow people to take greater control of their own personal data.

MAIN CHANGES

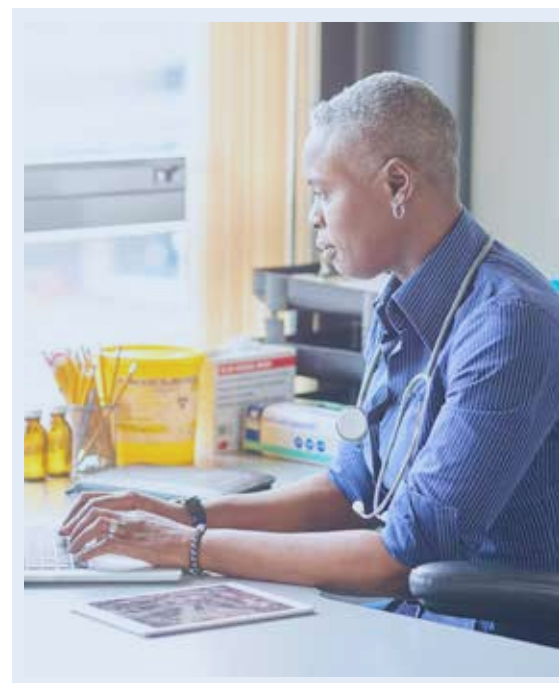
The list of changes outlined below is taken from the Data Protection Commissioner (DPC) guidance *The GDPR and You*.¹ The DPC has also launched a GDPR-specific website², with guidance for both individuals and organisations, raising awareness of their enhanced rights and responsibilities under the GDPR. The DPC has stated that there will be further guidance published in the coming months.

CONSENT AND LEGAL PROCESSING

The GDPR sets a very high standard for consent in relation to the processing of personal data. However, rather than relying on consent to process patient's data, practices are likely to also be relying on another appropriate legal basis for the processing of data.

Under the GDPR certain special categories of personal data – including data concerning health – cannot be processed (eg. collected, stored, used, disclosed or destroyed) unless there is a legal basis for doing so. You will need to establish a legal basis for processing health data and ensure this is communicated to patients. The most relevant legal bases for a GP will be:

- **processing that is necessary for the purpose of preventative or occupational medicine, medical diagnosis or the provision of health care or treatment that is done by, or under the responsibility of, a professional who is subject to an obligation of professional secrecy**
- **patient consent to processing.** If you rely on this as a legal basis for processing you will need to ensure it is freely given, specific and informed. It should constitute an unambiguous indication of the patient's wishes, by a clear affirmative action to the processing of his/her data. Pre-ticked boxes will not count as consent and there must be a positive opt-in process, separate from other terms and conditions. You will also be obliged to demonstrate that the patient has given their consent. It is not advisable to rely on patient consent as the sole legal basis for processing because consent can be withdrawn, and there should be an easy way for a patient to withdraw their consent.



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Data other than that falling within the special categories can be legally processed on slightly wider grounds, such as where the processing is necessary for the performance of a contract to which the patient is a party. If it is necessary to process the data to provide the service, then the practice can rely on that legal basis; however, contract is not a legal basis for processing health data.

TRANSPARENCY AND FAIR PROCESSING

Practices must inform individuals what they are doing with their data. Privacy notices should be used to inform patients at the time of collecting their data. These could be available on the practice website and as posters in the practice.



The following information must be provided within such notices:

- the data controller's identity
- the data protection officer's contact details
- the purpose of the processing
- the legal basis for processing
- the categories of personal data concerned
- the potential recipients of personal data
- how long the data will be retained
- the security measures in place to protect their data
- a list of the data subject's rights
- any safeguards that will be used if data is to be transferred to a country outside the EU.

In addition, patients must be informed that they can complain to the DPC if they believe there is a problem with how their data is being handled.

SUBJECT ACCESS REQUESTS

The timescale for compliance with a patient's subject access request will be reduced from 40 days to one month. Practices will no longer be able to charge, unless the request is manifestly excessive or unfounded. If practices refuse a subject access request, they must tell the patient why they have done that and inform them that they have a right to make a complaint to the DPC.

DATA BREACHES

In the event of a data breach affecting a patient's privacy rights (for example, breach of confidentiality), data controllers will be required to notify the DPC without undue delay, and where feasible no later than 72 hours after becoming aware of the breach. You will also have to notify the patient of the breach if it is likely to result in a high risk to their privacy rights. This is in addition to the duty of candour to inform patients of such breaches, outlined in paragraph 67 of the Medical Council's ethical guide.³

The DPC will have the power to impose higher fines for breaches of the regulation.

DPIAs

Data Protection Impact Assessments (DPIAs) are recommended as a way of assessing the level of protection in place to safeguard patients' personal data. Whilst considered good practice in any case, DPIAs will be legally required where the processing of personal data is likely to involve high risks to the confidentiality of individuals. They are likely to be required when practices introduce new technology, for example a new computer system or a new system of sharing data.

DATA PROTECTION OFFICER

Certain organisations will be required to have a Data Protection Officer (DPO), including public bodies and organisations that process special categories of personal data (including health data) on a large scale. There is currently relatively little guidance on determining what "large scale" means, but the number of patients concerned and volume of data being processed are material factors. The available guidance⁴ suggests that a hospital will require a DPO but an individual physician will not, but the threshold is not presently clear. You should conduct an assessment as to whether your practice requires a DPO, keeping a record of this assessment and your decision.

The DPO's role is an advisory and monitoring role, and cannot be someone who takes decisions about data protection. It is unlikely that the practice manager could take on this role, as there would likely be a conflict between advising on how to carry out processing in compliance with the GDPR, and taking decisions about how that should be done.

For guidance on how to ensure that your DPO is adequately resourced for the role, the DPC's guidance on appropriate qualifications for DPOs may be helpful.⁵

PATIENTS' RIGHTS

Individuals will be given stronger rights under the GDPR, including the right to rectification, the right to erasure, the right to object to processing, the right to restrict processing and the right to data portability. This final right makes it easier for patients to move their information from one data controller to another, and they will have the right to receive certain personal data in a structured, commonly used and machine-readable format. These rights are complex and not absolute. Practices should ensure that they understand when they apply and have a process in place to deal with them, should patients wish to exercise them.

KEY ACTIONS THAT PRACTICES CAN TAKE NOW

- Be aware that the law is changing and familiarise yourself with DPC guidance. Regularly check the DPC website at dataprotection.ie to review updates as they are published. Discuss who will lead this process within the practice.
- Start documenting now exactly what personal data you hold, how it is collected, how it is stored, who has access to it and who information is shared with. This includes personal data relating to your staff.
- Identify the legal basis for processing the personal data that you hold. If you are relying on consent, review how you seek, record and manage consent and consider if you need to make any changes.
- Review your current privacy notices and consider making changes now to ensure they are GDPR-ready. They should be translated into other languages as necessary to meet the needs of your patient population, and adapted for children and vulnerable patients so that they can be easily understood.
- Consider whether you need to appoint a DPO.
- Update your subject access request procedures; plan how you will handle requests within new timescales and provide records in the required formats.
- Develop a policy for reporting data breaches to the DPC, identifying who will assist and make decisions about what information to provide and when.
- Consider providing staff training on the changes over the coming months, so that they are all aware of their responsibilities in advance.

REFERENCES

1. [www.dataprotection.ie/docimages/documents/The%20GDPR%20and%20You.pdf](https://dataprotection.ie/docimages/documents/The%20GDPR%20and%20You.pdf)
2. www.GDPRandYou.ie
3. www.medicalcouncil.ie/News-and-Publications/Reports/Guide-to-Professional-Conduct-and-Ethics-8th-Edition-2016-.pdf
4. Article 29 Data Protection Working Party guidelines on Data Protection Officers http://ec.europa.eu/newsroom/document.cfm?doc_id=44100
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FACING THE CHALLENGES OF MODERN PRACTICE

Medical Protection's sixth annual GP conference took place in Dublin in September. Here we provide the key learning points that attendees discussed during the conference

READ THIS ARTICLE TO:



- ✓ Find out how our interactive events can help in your learning
- ✓ Understand the principles of good complaint handling

Medical Protection understands the challenges you face as a part of modern general practice and, as part of our support to you, we held our sixth annual GP conference in September, in Dublin.

Attended by more than 200 delegates, including GPs, GP trainees and practice nurses from across the country, the event had as its theme "Facing the challenges of modern practice" – and took a closer look at complaints and complaints handling in general practice.

Chair for the day was president of the ICGP – and member of MPS's Council – Dr Richard Brennan.

A TIME FOR CHANGE

The day opened with an insightful talk by Mr Fintan Foy, the newly-appointed CEO of the ICGP, who spoke passionately about the need for change in Irish general practice. Mr Foy stressed the need for more GPs to see the profession as the worthwhile and rewarding career it is: he added that the ICGP recently launched their own social media campaign, #BEAGP. The campaign aims to promote general practice as a career option for medical graduates, and also bring back home the many who have emigrated in recent years.

Following on from Mr Foy's keynote speech, Julie Price, Medical Protection's head of risk management and education consultancy, covered some key issues in general practice, including a practice's readiness for a possible HIQA inspection, prescribing process, communication within the team and being prepared for the new EU General Data Protection Regulations (GDPR), which come into force in May 2018. You can read more about these changes in our article on page 12.

Dr Paul Bowie, education consultant for Medical Protection's educational services team, then went on to discuss our new online safety tool – *Priority Safety Check 360*, which was also launched at the event. You can read more about this tool in our article on page 16.

MANAGING COMPLAINTS IN GENERAL PRACTICE

Currently Ireland does not have an official GP complaints process. If a patient wishes to make a complaint against a GP, the main port of call for a patient to lodge the complaint is to the Medical Council. Practices do not have an opportunity to discuss a patient's complaint at practice level.

At Medical Protection, we recognise this is a concern for members; the remainder of the morning session was handed to a panel of experts to discuss the pros and cons of introducing a complaints handling process for general practice.

PANEL DISCUSSION

The panel consisted of:

- **Dr Mary Favier, GP and former member of MPS Council**
- **Dr Brendan O'Shea, director of the Postgraduate Research Centre, at the ICGP**
- **Mr Michael Kilcoyne, of the Dental Complaints Resolution Service, who drew parallels in complaints handling across medicine and dentistry**
- **Dr Sue Boynton, dentolegal adviser at Dental Protection**
- **Mr William Kennedy, director of regulation at the Medical Council.**

Dr Favier's opening talk to the audience set the theme for the session. She spoke about the raft of emotions a GP experiences on receiving that letter of complaint from the Medical Council: the hurt, pain, anger, rage, sadness, shame, resentfulness, denial. Dr Favier also went on to discuss the length of time it took for a complaint she received to come to resolution, and the pain she, as a GP, and her practice team went through as a result of this.

Mr William Kennedy provided the conference with a breakdown of complaints received by the Medical Council, reporting that:

- **46% of complaints received by the Medical Council in 2016 were made in relation to GPs.**

Approximately 86% of these complaints concluded with no further action taken. Of these:

- **8% were made in relation to medical records**
- **33% were made in relation to communication issues**
- **28% were made in relation to treatment.**

Could many of these have been dealt with at local level rather than the Medical Council?

Dr O'Shea spoke about the complaints handling systems within the co-operatives around the country, with a particular focus on the robust systems they have in place in his own co-op, K-Doc.

Dr Boynton and Mr Kilcoyne went on to discuss how the Dental Complaints Resolution Service was established, how this system works and its successes in mitigating complaints and stopping many spurious complaints from reaching the Irish Dental Council. Could general practice learn from this and can something similar work for GPs in Ireland?

The expert panel session was followed with small facilitated workshops, hosting discussions on the types of complaints handling procedures that already existed at local levels. The discussions looked at the successful and less successful procedures among them, which varied widely from posters to suggestion boxes, to nothing at all.

OUTCOME OF SESSIONS

From the workshops it was clear that many delegates would welcome having a feedback system, where patients could raise concerns and complaints at a local level rather than going straight to the Medical Council. One of the fears of GPs was receiving a letter from the Medical Council and having a similar experience to that described by Dr Favier.

However, there was also some reticence among some delegates to advertise a complaints procedure, as it was felt that this was welcoming complaints and would make things too difficult in the practice.

In addition, people preferred the term 'Feedback' to complaints.

Medical Protection will be developing material for general practices on how to manage complaints at local level, which will include a feedback policy, information for patients, a workshop for practice staff and a poster to display in your practices; eg, encouraging patients to 'have their say' with both positive and negative feedback.



WORKSHOPS

Delegates then broke for lunch and returned to their choice of workshop for the afternoon. Topics included:

- medicolegal dilemmas
- the GP commercial landscape
- learning from events
- managing test results
- infection control.

FINAL SESSION

The afternoon was wrapped up with a question and answer session involving a panel of experts.

SUMMARY

Feedback was overwhelmingly positive, with 99% of delegates confirming they would like to attend the event again. Comments included:

"Have attended for the past number of years. Very informative and always great workshops every year."

"Thank you for the empowerment. A very important meeting that all GPs should attend."

"Excellent event."

"Thank you for the opportunity to discuss complaints procedures and learn from others' experience."

"Thank you to all who attended and participated in the event, making it an enjoyable and informative day. We hope to see you all again next year."

FURTHER LEARNING

Medical Protection has a host of extra resources available to you free as a benefit of membership. Workshops, online learning and clinical risk assessments cover various risks in Irish general practice – visit medicalprotection.org to find out more.

PRIORITYSAFETYCHECK360:

IMPROVING SAFETY SYSTEMS IN GENERAL PRACTICE

Dr Paul Bowie, Kate Taylor and Julie Price emphasise the importance of checklists in healthcare – and introduce an effective new tool from Medical Protection

READ THIS ARTICLE TO: ✓

- ✓ Learn how checklists can improve patient safety
- ✓ Find out about a new tool from Medical Protection that can help

SAFETY IN GENERAL PRACTICE

In the majority of cases, patient care in general practice is of good quality and is largely uneventful from a safety perspective. However, with so many patient consultations taking place every day in Irish primary care, there remains the potential for things to go wrong at some point in most practices.

WHY DO WE NEED SAFETY CHECKING PROCESSES?

Outside the clinical consultation, wider organisational problems also contribute to patient safety, staff wellbeing and overall practice performance. Inconsistent and unreliable checking processes are contributory factors in many safety incidents, eg, the unsafe management of controlled drugs or inadequate emergency equipment maintenance.¹

Additionally, everyday workloads, stresses and distractions often affect our memory span and attention to detail – a common problem that affects everyone. This means we may forget to undertake necessary checks of important safety tasks as planned, or don't do them on time, which can lead to things going wrong.

SAFETY CHECKLISTS IN HEALTHCARE

The routine use of checklists to minimise risks is standard practice in many safety-critical industries such as those found in the aviation, petro-chemical and railway sectors. In healthcare, as part of the evolving patient safety agenda worldwide, there is growing interest in 'checklists' to standardise necessary checking processes and act as cognitive aids to help ensure 'high reliability' in task completion by care teams.

For example, progress is now being made in hospital theatres with the introduction of the World Health Organisation surgical safety checklist to reduce the risk of patient complications and deaths, resulting in marked improvements in surgical outcome eg, postoperative complication rates fell by 36% on average, and death rates fell by a similar amount.²

ABOUT PRIORITYSAFETYCHECK360

Medical Protection have adapted and redeveloped an easy-to-use tool – *PrioritySafetyCheck360* – which provides member and non-member practices with a targeted checklist, for use when carrying out primary care safety checks.

The aim of *PrioritySafetyCheck360* is to ensure that safety-important tasks are checked on a timely basis and necessary action is taken, where needed, to improve practice systems (eg, emergency drugs are available and in-date). The tool is adapted from a previously-developed safety checklist for the GP working environment.³

The checklist and its content were rigorously developed, validated and tested in a co-design process with many different GPs, practice managers and practice nurses contributing. *PrioritySafetyCheck360*, therefore, was fully developed by GP team members for GP team members.

The content of the checklist covers six safety domains (see Box 1). Within these categories there are a total of 62 priority items to be checked. The checklist should be consistently applied at least four times per calendar year; previous testing suggests this takes an average of 90 minutes. Common sense judgments should be applied to those items that, for example, need to be checked annually or may not be applicable to all practices (for example, stocking of controlled drugs).

The content of *PrioritySafetyCheck360* has been categorised as follows to help the GP team prioritise related risks and improvement actions (see Box 2 for examples):

- **Mandatory** – 'where a legal, professional, contractual or regulatory obligation existed for the check to take place'
- **Essential** – 'where a failure to check the item would have the potential for harm to occur to patients, GP team members, or practice visitors, or impact negatively on the performance and reputational risk of the practice'
- **Advisable** – 'where periodic checking of the item would be a voluntary demonstration of high quality safe system practice'

SUCCESSFUL IMPLEMENTATION OF PRIORITYSAFETYCHECK360

The vast majority of practice managers who helped populate the items in *PrioritySafetyCheck360*, or who have come into contact with it since then during conferences and workshops, have strongly suggested that this integrated approach is better, safer and more efficient than what they were doing previously in their own practices.

It needs to be remembered that the prevailing safety culture within a practice will also influence how seriously this approach is taken, ie, the checklist tool itself will not make the practice processes safer. Like any improvement activity, this is always down to the leadership, team-working and commitment of the GP team – the practice manager has a pivotal leadership and co-ordination role in this regard.

To register for the *PrioritySafetyCheck360*, please visit medicalprotection.org.

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1. The Safer Primary Care Working Group, Safer primary care. A global challenge, Geneva: WHO, report no WHO/IER/ PSP/2012.16 (2012)
2. Haynes AB, Weiser TG, Berry WR et al, A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population, *N Engl J Med* 360:491-499 (2009)
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BOX 1 - PRIORITY SAFETY CHECK 360: DOMAINS, CATEGORIES AND ITEMS

MAIN SAFETY DOMAINS (N=6)	EXAMPLE OF CHECKLIST CATEGORY (N=24)	EXAMPLE OF CHECKLIST ITEM (N=62)
1. Medication safety	Controlled drugs	Stock balances are undertaken at appropriate time intervals based on practice usage
2. Housekeeping	Stocking of clinical rooms	Adequate PPE (Personal Protection Equipment) is available
3. Information systems	Data protections	Latest software updates for all information systems are installed (e.g. Formulary, EMIS, Vision)
4. Practice team	Registration checks	All clinicians are registered with the appropriate regulator
5. Patient access and identification	Standardised patient identification (ID) verification	The practice has a patient ID process using two approved patient identifiers and the practice team can describe how it is applied
6. Health & Safety	Building safety and insurance	Public and employer's liability insurance are up-to-date and displayed

BOX 2 - EXAMPLE OF MEDICATION SAFETY DOMAIN ITEMS CATEGORISED BY MANDATORY, ESSENTIAL AND ADVISABLE

	MEDICATION SAFETY	CATEGORY
	CONTROLLED DRUGS	
1.	Securely stored	MANDATORY
2.	Up-to-date register exists	MANDATORY
3.	Stock balances are undertaken at appropriate time intervals based on practice usage	MANDATORY
4.	Any out-of-date stock is appropriately disposed	MANDATORY
	EMERGENCY DRUGS & EQUIPMENT	
5.	Your usual supplies are available in sufficient quantities	ESSENTIAL
6.	Evidence of monthly stock check and expiry date rotation	ESSENTIAL
7.	Evidence of monthly equipment check (eg, nebuliser, defibrillator, airways, anaphylaxis)	ESSENTIAL
8.	The location of emergency equipment is adequately signposted throughout the premises (eg, prominent notice in each room)	ESSENTIAL
	PRESCRIPTIONS & PADS	
9.	Securely stored	MANDATORY
10.	Serial numbers for prescription pads are recorded and stored	MANDATORY
	VACCINATIONS	
11.	Cold chain temperature recording at least once daily	MANDATORY
12.	Storage facility is locked and alarmed	ESSENTIAL
13.	Evidence of expiry date rotation	ESSENTIAL
14.	Your usual supplies are available in sufficient quantities	ADVISABLE
	ALL OTHER DRUGS ON PREMISES	
15.	Storage facility is secure	ESSENTIAL
16.	Evidence of expiry date rotations	ESSENTIAL

MAKING THE CASE FOR REFORM



Hilary Steele, Medical Protection claims lead for Ireland, describes how we have influenced change in the legal system that could benefit you

READ THIS ARTICLE TO:



- ✓ Learn about Medical Protection's policy work
- ✓ Find out how we have influenced legal reform to your benefit

With increases in member subscription rates, caused by the rise in the cost of clinical negligence, these are challenging times to be a doctor in Ireland.

This is why it is increasingly important that, at Medical Protection, we take an active role on behalf of you to tackle the issue and the increasing burden this is placing on both the State and members.

We work hard behind the scenes to shape policy, reforms and regulations that directly affect you on a day-to-day basis. With more than 16,000 members in Ireland – more than 2,500 of whom are GPs – and over 300,000 members worldwide, our knowledge and experience of the global medicolegal environment puts us in a strong position to advise and inform policy-makers.

TAKING ACTION

It is particularly concerning that legal costs often exceed the compensation awarded to the patient. This is hard to justify and requires reform.

An efficient and predictable legal process for handling clinical negligence claims is needed and, in our 2014 report *Challenging the cost of clinical negligence* – the case for reform, we set out some bold but achievable recommendations that can make a real difference to the cost of claims, benefiting all parties concerned.

These include procedural reforms, to encourage greater predictability and earlier resolution of claims, and limits for compensation payable to patients.



EARLIER RESOLUTION OF CLAIMS

Among these reforms, we have successfully enabled the introduction of a voluntary pre-action protocol, which is a process that provides the opportunity to investigate a claim and resolve it without going to court.

The protocol is designed to encourage openness and transparency while reducing pressure on the courts, thereby allowing earlier resolution of both litigated and non-litigated claims to the benefit of all parties.

When introduced, the protocol will set out what information parties must provide to one another. Currently, we cannot compel claimant solicitors to provide the information we need in order to resolve a claim without court proceedings. This leads to delays that, understandably, are frustrating for members.

We are working closely with the State Claims Agency and four of Ireland's leading clinical negligence claimant firms to introduce the voluntary protocol by the end of 2017. We will share our experience with the Department of Justice during the statutory consultation process to help shape the future of claims resolution in Ireland.



Our **Learning From Events** workshop takes place in your practice, inviting the whole team to learn from adverse incidents.



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