Your Practice

PROFESSIONAL SUPPORT AND EXPERT ADVICE FOR GP PRACTICES

Putting members first

VOLUME 1 | ISSUE 1 | SEPTEMBER 2012

Your practice your risk

COMMON RISKS IN GENERAL PRACTICE

PAGE 8

Inside this issue:

How well are you tackling CPD?
Audit: Good for patients and good for doctors
Faxing patient information – top tips

www.medicalprotection.org
The right choice for GPs in Ireland

MPS is the world’s leading medical defence organisation, putting members first by providing professional support and expert advice throughout their careers.

The right choice for indemnity
There is often a gap between an adverse incident occurring and a complaint or claim being brought against a GP. If you have MPS membership in place you can ask us at any time for help with an incident that occurred while you were a member – even if it is years later that the problem arises.

The right choice for professional protection
MPS comprehensive indemnity is provided on a discretionary basis. We are not restricted by detailed terms, conditions and exclusions. There are no financial caps on the indemnity we can provide and no excesses for you to pay. We recognise that medicine and the law change every day and we have the flexibility to work with you to try and find a solution to your problem.

Education for GPs in Ireland
Using our wealth of knowledge and experience of supporting GPs in Ireland we have developed a range of education and risk management resources that can help you avoid problems and provide the best care for your patients. The portfolio available includes:

- Publications
- Conferences
- Lectures
- Presentations
- Workshops throughout the year
- E-learning
- Clinical Risk Self Assessments.

Keeping us informed: In order to ensure we can provide the best possible support should the need arise, please keep us informed of any change in your circumstances.

Call: 1800 509 441  Online: www.medicalprotection.org/ireland
Email: member.help@mps.org.uk
Welcome to the very first edition of Your Practice, a magazine for the whole practice team.

Recent research with GPs in Ireland identified that you would like practical tips on risk management and medicolegal issues for your whole practice. We have listened to this feedback and Your Practice has been designed to meet your needs. The aim is to provide you with an entertaining read, keeping you up-to-date with topical issues and giving you practical tools that you can use in your practice.

All GP practices are different; yours might be single-handed, or it might be large enough to provide specialist clinics such as minor surgery. Whatever the size or demographic of your practice, some of the most common risks remain the same. In ‘Your practice, your risk’ on page 8, we hear first-hand from a practice which has benefitted from MPS’s Clinical Risk Self Assessment scheme. We also provide some practical tips on how to avoid the most common pitfalls in areas such as communication, record-keeping and confidentiality.

Continuing Professional Development has been a high priority since the introduction of the professional competency scheme last year. We take a look at the best ways to ensure you are complying with the Medical Council’s requirements – through individual CPD, and through auditing your practice as a whole.

I hope you enjoy this edition and you find it both informative and useful. We’d be very interested to hear your comments on this first issue, and any ideas or topics that you’d like us to focus on in the future.
Update

Bringing you the news that affects your practice

Events and conferences round up

During 2012, MPS has been very active in Ireland. We provided sponsorship and speakers for the ICGP National Trainers Conference in February and the ICGP AGM in May. MPS’s Clinical Risk Programme Manager, Julie Wilson, spoke at the ICGP Summer School in Kilkenny in June, delivering a workshop on medical records.

In addition, on Thursday 13 September, MPS hosted its first General Practice Conference: Spotlight on Risk, at the Irish Management Institute in Dublin. This conference focused on the top risks in general practice, giving the whole practice team advice on how to manage them. Topics covered included:

- Top risks in general practice – medical records, confidentiality, handover and chaperones
- Performance reviews and competence assurance
- Claims experience in Ireland and how MPS manages claims
- What happens when a complaint or claim is made?

The conference also featured workshops on: Medicolegal Dilemmas, Medical Records, Challenging Interactions with Patients and Complaints – Getting the Best Result.

Upcoming events

**NAGPT Annual Conference**
11-12 October 2012, Lyrath Estate Co. Kilkenny

MPS is the sole sponsor of this year’s NAGPT (National Association of GPs in Training) conference in October. We are proud to have been associated with the conference for more than eight years. More than 250 GP trainees will attend and the main emphasis will be on research in general practice.

For booking details and further information visit: [www.icgp.ie/go/become_a_gp/training_news/](http://www.icgp.ie/go/become_a_gp/training_news/)

**ICGP Study Day for Carlow and Kilkenny GPs**
13 October 2012

MPS’s Julie Wilson will be speaking at the event.

For more information on MPS’s conferences and events, visit the website at: [www.medicalprotection.org/ireland/education-and-events/conferences-and-events](http://www.medicalprotection.org/ireland/education-and-events/conferences-and-events)

Protecting your interests

Not only does MPS support doctors when things go wrong, we also closely monitor the regulatory environment and make representations to decision-making bodies and parliamentarians to protect and promote our members’ interests.

Back in February, MPS hosted a reception in Dublin for more than 70 stakeholders in healthcare, where it shared the organisation’s recent medical and dental claims experience, as well as the medicolegal challenges on the horizon in Ireland. Hosted by MPS Chief Executive Simon Kayll, the event was held at the Royal College of Physicians of Ireland.

A major focus for us is on whistleblowing, and we are campaigning for the need to create a culture of openness when reporting concerns. Raising concerns about patient safety is a professional responsibility and organisations must support staff who do so. Such openness must also apply when healthcare staff report patient safety concerns.

We provide a confidential helpline for all members, who can contact us when dealing with issues surrounding whistleblowing. The government has announced their intention to publish proposed legislation dealing with the protection of whistleblowers – we will be closely monitoring developments.

NEWS IN BRIEF

**National Standards published**

The Health Information and Quality Authority have produced new guidance, National Standards for Safer Better Healthcare.

The Standards have been designed to protect patients in all healthcare settings, including GP practices. They provide a strategic approach to improving safety, quality and reliability in health services in Ireland for the first time and will form the basis for future licensing of all healthcare facilities.

For more information visit: [www.hiqa.ie/standards/health/safer-better-healthcare](http://www.hiqa.ie/standards/health/safer-better-healthcare)

**Drink/drug abuse is investigated amongst doctors**

The Medical Council’s health committee investigated 20 doctors who were abusing drugs and alcohol in 2011, amid concerns about patient safety.

The health committee was established to try to help and monitor doctors with health problems, rather than sending them straight to a disciplinary inquiry.

Figures, published in the Medical Council’s annual report, revealed that ten of the doctors were referred to the committee suffering from some form of mental disability.

The report also revealed that there were 367 complaints in 2011, up from 314 in 2010. However, just 39 doctors were found to have a case to answer.

Apart from doctors who were struck off, six had conditions added to their registration, which they needed to comply with in order to be allowed to continue to practise.

For more information visit: [www.independent.ie](http://www.independent.ie)
Primary care teams – why have they struggled?

At the core of the 2001 national health strategy – Quality and Fairness: A Health System for You – was the primary care strategy. It placed primary care teams and networks as the firm foundation of a radically restructured health system. But more than a decade on, why are they still struggling for viability, asks Dr Muiris Houston

The primary care strategy’s timeline for implementation promised that between 400 and 600 functioning primary care teams (PCTs) would be up-and-running by the end of 2011. However, in its annual report for last year, the Health Service Executive said there were some 425 PCTs “at various stages of maturity and development”.

The gulf between fully functioning and various stages of development is reflected in the frustration felt by many GPs towards PCTs. Sadly, a number of individual adopters who had set up apparently successful PCTs have become disillusioned with the bureaucratic roadblocks following the first flush of success.

Areas of concern
Assigning patients to teams based on their geographical location rather than general practice registration represented a fundamental flaw in the methodology employed to define a PCT, according to Dr Margaret O Riordan, the author of the report.

Reporting arrangements were another area for concern, with widespread difficulty ascertaining who was in charge as different team members reported to multiple managers. “This silo effect where team members are reporting to largely hospital based discipline managers is not conducive to team cohesion and productivity,” the report noted.

Discouragingly, for those teams operating successfully, the services they currently provide are starting to disintegrate due to waiting list delays for access to community services. Also the damaging effect of the public service jobs embargo effectively means, for example, that when an occupational therapist leaves a team he or she cannot be replaced.

For GPs who have yet to commit to a PCT, watching this disintegration of services is a major disincentive to joining a team: not unreasonably, they perceive no benefit for their patients and a lack of true commitment on behalf of the HSE and Department of Health to primary care development.

Given the commitment in the coalition government’s plan for the health service to get rid of the two-tier system, it is especially discouraging to see differences emerging in how private and public patients are treated by PCTs. In a reversal of traditional inequities in the health system, some see no private patients, while others operate a quota system, where a limited number of private patients are seen every year.

Speaking to Your Practice at the ICGP AGM in May, the Chief Executive of the college said that there had been little progress in the development of PCTs since the November report. Kieran Ryan said about one-third of primary care teams were working effectively while a further one-third were partly functioning. Another third existed in name only.

A positive experience
However, it is not all doom and gloom at the coalface of primary care. Dr John Latham, a south inner city GP in Dublin, speaks highly of his eight-year involvement with his local PCT: “Formal meetings are a fantastic opportunity to approach difficult clinical or social problems with a broad range of skills and knowledge; as a GP my patient’s care is greatly enhanced by this.

“Meetings over coffee or even in patients’ homes are frequent and fruitful. The ability to refer rapidly to other disciplines, eg, physiotherapy within one’s team, is great for patients.”

Dr Latham adds that in his view, GP job satisfaction will be enhanced as more and more practices join properly functioning multidisciplinary teams and provide even more integrated and timely care.

So what does the future hold for PCTs here? Clearly, there is a need for a significant recommitment to the concept by both the HSE and the Department of Health. This must go beyond rhetoric and involve a dedicated national taskforce with the authority to go to the aid of functioning teams whose future is now threatened.

Only when this is successfully and visibly undertaken can we realistically expect family doctors to consider investing their professional futures in the expansion of PCTs.
How well are you tackling CPD?

The Medical Council introduced Professional Competence in May 2011. Dr Gerry Mansfield, ICGP National Director of Specialist Training in General Practice, answers our questions about how to get the most out of CPD – and make sure you are hitting the right mark.

CPD came into force in May 2011. What teething problems have there been? Do you think GPs have adapted well to the new system?

General practitioners have pioneered the adoption of information technology in Irish healthcare. This has facilitated a relatively smooth introduction of an electronic system of recording GPs’ learning activity.

Successful CPD depends on an accurate assessment of your learning needs. What do you think is the best way for GPs to identify their professional shortcomings in order to plan their learning requirements successfully?

Personally, I think that a combination of a reflection on my own practice each day, and the feedback from my practice colleagues/CME group, helps me to plan my learning requirements in the most effective way for me.

Acquiring credits from external organisations (eg, attending a conference or workshop) is easy to account for, yet “practice-based” learning activities might appear to be harder to define. What different or useful practice-based learning activities have you come across that you could recommend?

Case-based discussion at practice lunch meetings is invaluable. The contribution from practice nurses, physiotherapists and the other members of primary care teams (where available) adds a whole other dimension to cases.

Journal clubs don’t have to take vast amounts of time, but still offer a high yield in terms of learning and continuing professional development, especially when under time pressures in a busy general practice.

What would you say to GPs who are worried they might not be able to collect all their CPD points in one year? Any top tips to ensure success?

It takes time to adjust to any new system, but thankfully this hasn’t been a major problem or issue. Personally, the long-established Continuing Medical Education (CME) structure plays a vital role in meeting ‘internal’ and ‘external’ learning needs.

Similarly, the wide spectrum of established courses provided by the ICGP facilitated ample opportunity for doctors to pursue areas of individual interest.

We are all getting used to recording the various learning activities and I certainly hope to get better at updating as I go along. I know I and other colleagues have struggled at times with what constitutes an ‘internal’ credit, but feel happier now with the differentiation from other learning activities.

What sort of thing counts as evidence of CPD, and what checks are in place to ensure GPs are hitting the right mark?

Evidence of CPD includes certificates of attendance and records of meetings. There also has to be a degree of trust that we are all accurately recording the activities we have engaged in to maintain our professional competence.

The Medical Council will audit a percentage of all doctors enrolled in the professional competence scheme and ask for evidence of our CPD activities and clinical audit. We have a statement from the scheme we are enrolled in which provides this detail. If the Medical Council determines that we are not “hitting the mark”, advice on how we should improve will be discussed.

The postgraduate medical training bodies which operate the professional competence schemes under arrangement with the Medical Council have established and expanded the range and scope of educational activities to support GPs with maintaining their professional competence.

MPS offers a range of education and training that can help you avoid problems and provide the best care for your patients. The portfolio available includes: communication skills workshops, journals, E-learning and Clinical Risk Self Assessments. Many of the services available are applicable for internal or external CPD credits. For further information, please visit www.medicalprotection.org/ireland
Audit: good for patients and good for doctors

Some more complex audits are geared towards patient safety:

■ An analysis of patients on immunosuppressants or methotrexate – Generate a patient list using a computer medication search. Assess whether blood test monitoring is undertaken in accordance with recommendations in the BNF (gold standard). Identify any inadequate or excessive phlebotomy and put a system in place to ensure appropriate monitoring – I link phlebotomy to duration of prescription and issue a two or three month prescription only. Repeat the cycle and close the audit loop.

■ Are immunocompromised patients appropriately vaccinated for influenza or pneumococcal? – The next update of the national guidelines in immunisation will feature a section devoted to vaccination of immunocompromised groups – a good audit opportunity.

■ The prescription should specify the day of the week to take the methotrexate – perhaps another audit? – Consider putting patient safety information on the prescription, eg. “If you become unwell or feverish, contact your doctor urgently and explain you are taking methotrexate." This could be a further audit?

■ Flu vaccination and pregnant women – Irish guidelines recommend we vaccinate “all pregnant women at any stage of pregnancy”. Check how many antenatal women who delivered a baby last November, December and January had the flu vaccination. Discuss with the practice team and pregnant women at booking, combine with computerised reminders or “pop-up alerts”, and complete the audit cycle next winter.

Identify best practice: what is the gold standard?
NICE, Cochrane and SIGN are useful references. Ask the ICGP or your local university department of general practice. Use their expertise to help this key activity. Delegate, delegate, delegate!

Collect your data
Make life easy and get someone else to do this for you! Computerised disease registers facilitate audit and closing the audit loop. Medication searches on the computer, or a friendly local pharmacist, can help identify the patient population. Be generous and share the learning experience – ask a medical student or GP trainee to help with the work. The sample size required is often blindingly obvious. If smoking status/BMI/ethanol intake is rarely documented, you don’t need to plough through 500 charts for a valid sample size. Computerised registers make it much easier to complete the audit cycle at a later date. Conserve your energy for the inevitable workload in managing change.

Quality improvement and change management
Challenging and changing ingrained work practices is never easy, at both individual and practice level. Don’t underestimate the challenges this step presents to successful audit. Identify and minimise barriers to change. One size doesn’t fit all – use multiple interventions to promote change – guidelines, interactive education and computerised reminders all have a role to play. Finding sufficient protected time in a busy week to undertake audit is a challenge we all face.

Complete the audit cycle
Improving care is the primary purpose of audit, and sustaining that improvement is essential. Collection of data subsequent to the proposed changes is key to demonstrating sustained quality improvement. Complete the audit cycle to reinforce good practice within a supportive practice environment. Concern for quality should permeate all aspects of practice, demonstrated and sustained by appropriate audit.

In summary
Audit can be fast and simple, or hugely complex. Changing work practices is easier said than done. However, it is professionally very satisfying to demonstrably improve clinical practice. Audit is good for doctors and good for our patients: a win-win situation for all.

REFERENCES
1. NICE, Principles for best practice in clinical audit. 31 July 2008
2. www.medicalcouncil.ie/Registration/FAQ/Professional-Development accessed 14 June 2012

GPs are required to conduct at least one practice audit each year.

Dr Diarmuid Quinlan, a GP based in Glanmire, Cork, explains where to start

Audit can be easy to complete, improve your diagnostic skills and reduce your workload. Audit:

- Should improve patient management, patient safety and clinical outcomes.
- Should improve the quality of everyday care to our patients.
- Is the component of clinical governance that offers the greatest potential to assess the quality of care routinely provided.¹

What is clinical audit? (The technical bit)
Audit is best described as following a (virtuous) circle. First, identify best practice, measure existing care, implement change to improve care, and monitor to sustain improvements. The circle is continuous, with each cycle aspiring to a higher level of care.

The setting of standards, measurement of practice compared to a ‘gold standard’, identification of deficiencies and addressing deficiencies (closing the loop) is clinical audit.²

What errors and shortcomings can be constructively addressed?

Getting started
Interesting topics should be clinically important and measurable. Keep it simple for the first few audits – you could look at documentation of smoking status, alcohol intake, or BMI of patients. These three starter audits will see your auditing requirements completed through to 2015!

Audit can be constructive and satisfying to demonstrably improve clinical practice. Audit is good for doctors and good for our patients: a win-win situation for all.

Dr Diarmuid Quinlan, a GP based in Glanmire, Cork, explains where to start...
H ave you made a mistake today? Given out the wrong prescription, prescribed the wrong dose, or scanned a letter into the wrong patient’s record? It’s easily done; we are all human and we will all make mistakes. General practice is a risky business; it is hectic, sometimes stressful, and often involves working long hours. You may worry about receiving a complaint or a claim, and find yourself asking: “How do I prevent making errors and ensure my patients are safe?”

To prevent errors, it is important to first identify the reasons why they occur. According to Mike O’Leary, ex Chief Executive of British Airways, “Accidents rarely happen without warning. The sequence of failure and mistakes that cause an accident are unique but the individual failures and mistakes rarely are.” His sentiments are echoed in the work of renowned cognitive psychologist Dr James Reason. He began to explore human error after he put cat food in his teapot, while making tea and feeding the cat. The two components got mixed up; both the teapot and the cat’s feeding dish afforded the same opportunity – putting stuff in.

Dr Reason created the “Swiss cheese” model to explain human fallibility, which is made up of two approaches: the active (person) and the latent (system). The active failures are the unsafe acts committed by people who are in direct contact with the patient or system. These take a variety of forms: slips, lapses, mistakes and procedural violations. Latent failures arise from decisions made by management etc and these decisions have the potential for introducing failure into the system. For example, time pressures, understaffing, or inadequate training.1

The “Swiss cheese” model illustrates the trajectory of an accident. The holes in the Swiss cheese represent the failures in the system’s defences that allow a hazard to pass through. So error is a combination of human and system failures. Even the best of us make mistakes, so it is important that systems are robust to make these mistakes due to human fallibility less likely.

Patient safety is intrinsic to MPS and one of our aims is to work with healthcare professionals through education and risk management to prevent avoidable harm to patients. To meet this aim, we have developed a Clinical Risk Self Assessment (CRSA) for general practice. A CRSA is a systematic approach to identifying risks and developing practical solutions to ensure quality of practice, and preventing harm to patients, ie, making the systems in your practice safer.

Over the past nine years MPS have conducted more than 800 Clinical Risk Self Assessments (CRSAs) in general practice across the UK and Ireland. The data collected, analysing the results of more than 150 CRSAs conducted during 2011, reveals a wide range of risks that are widespread across practices. (See box 1).

Below, we offer some tips on how to mitigate risk in each of these areas.

Communication
Fundamental to patient care is communication – between all members of the practice and between the healthcare team and the patient.

- Consider a schedule of regular meetings to develop policies, share information and to listen to your staff’s ideas, suggestions and concerns.
- For all the meetings provide an agenda, take minutes of the meeting, record decisions made and give details of any actions required, timescales for the action to be undertaken and the name of the designated person undertaking them. Ensure all staff receive a copy of the minutes.
- Discourage interruptions to the doctors when they are in surgery – these may inadvertently cause the doctor to lose their train of thought.
The sequence of failure and mistakes that cause an accident are unique but the individual failures and mistakes rarely are and may also result in a breach of confidentiality. Provide guidelines for administrative staff detailing the reasons when interruptions are acceptable and when they are not; ensure that interruptions are always kept to a minimum.

- Discourage the use of Post-it® notes or pieces of paper in favour of an electronic messaging system, so that key information is not lost.
- To improve communication with patients, ensure that there is an up-to-date practice leaflet and website that includes details such as practice services and opening times. Consider whether there is a need to publish the leaflet in other languages.
- Only send text messages to those patients where consent has been recorded. Ensure a record of any text message is made in the patient’s file.

Confidentiality
All patients are entitled to privacy and dignity.

- In 77% of practices visited, there was the potential that patients would be able to overhear conversations at the reception desk. Consider reviewing the layout of the reception, repositioning computer screens, or moving telephones away from the front desk to help maintain confidentiality.
- In 53% of practices visited, patient-identifiable information was left on consulting room desks. Ensure patient information is not left lying around.
- In the majority of practices visited, staff had signed a confidentiality statement, but these did not always contain a clause relating to post-employment.
- Ensure that staff are trained in confidentiality issues and that the message is regularly reinforced.
- Consider developing a ‘fax policy’ (see page 11).
- Consider the security of staff members’ medical records, both paper and computer records. Store paper medical records in a separate locked cabinet with access restricted to relevant healthcare professionals when required. Restrict access to staff members’ computer records to healthcare professionals only.

Health and safety
All practices must provide a safe environment for both patients and staff in order to comply with health and safety regulations.

- Nominate a designated and trained health and safety lead and undertake a documented health and safety risk assessment.
- Ensure that sharps and waste are stored and disposed of securely.
- Ensure the security of all staff, eg, by installing panic alarms, and by arranging training in dealing with violence and aggression.

Prescribing
Medication errors contribute to about 20% of all errors occurring in general practice; many of which are preventable. Common examples include: wrong dose, inappropriate medication and failure to monitor for toxicity and side effects.

- 48% of practices visited during 2011 did not have a robust repeat prescribing protocol. Ensure that your practice has one and all staff are trained in and have access to the protocol, which should be dated and regularly reviewed.
- Ensure that the procedure of generating repeat prescriptions is undertaken with due care and attention, ideally in a quiet location and free of interruption, when full concentration can be given to the task.
- Best practice indicates that medication added to the prescription list should be done by the GP. If medication is added to the computer, or changed by administration staff, it must be closely checked by the doctor afterwards. Considerable care needs to be taken to ensure that all the details are correct and that it has been added to the correct patient record. The doctor has responsibility for the prescriptions he/she signs.

- Ideally, GPs should undertake patient medication reviews on a regular basis. Some practices we have visited do this for each patient on a yearly basis using the birth date as a reminder. Any repeat medication that is not currently in use should therefore be deleted from the repeat medication screen.
- Patients with same/similar names should provide three unique pieces of information to aid identification of the correct patient.

Record-keeping
Complete and contemporaneous records are essential for ensuring good quality patient care and are needed if a complaint or claim is made.

- Ensure that all consultations are contemporaneously recorded and are sufficiently detailed and accurate so that a colleague could safely and seamlessly continue the patient’s care. Records that secure continuity of care will also be adequate for evidential purposes.
- Ensure letters scanned on to a computer are saved into the correct record.
- Always record telephone advice and home visits.
- Ensure everyone adds allergies in the correct way to the medical record.
- Routinely maintain a “black book” (aide memoir) or the electronic equivalent for referrals, critical test results and other key information. When appropriate dictate the referral in the presence of the patient.
- Encourage patients to notify the practice of any change in personal details, eg, address, mobile telephone number and next of kin details. Any of the following methods could be used to remind patients: notice in waiting room, website, newsletter, right hand half of prescriptions, at the time of referral.

Overcoming risk
Managing risk is a continuous process of evaluation, action and re-evaluation. Risk management should be a dynamic process, involving all members of the practice team.

CONTINUED OVERLEAF

REFERENCES

Box 1: Top five risks in general practice

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<th>Rank</th>
<th>Risk</th>
<th>Percentage of practices with risks by risk area</th>
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<tr>
<td>1</td>
<td>Communication</td>
<td>99.4%</td>
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<tr>
<td>2</td>
<td>Confidentiality</td>
<td>98.7%</td>
</tr>
<tr>
<td>3</td>
<td>Health and safety</td>
<td>97.4%</td>
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<tr>
<td>4</td>
<td>Prescribing</td>
<td>87.8%</td>
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<tr>
<td>5</td>
<td>Record-keeping</td>
<td>87.2%</td>
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Mary Street Medical Centre aims to provide each patient with excellent, easily accessible and caring and continuous family medicine. We are five Doctor Principals working with five practice nurses and 12 support staff. We service a mix of rural and urban with a practice of population of 16,000 (seen in the last three years).

We also provide some specialist clinics: minor surgery, dermatology, cryosurgery, dexa scanning, travel vaccinations, audiometry, cardio-metabolic diabetic and counselling services. As part of a primary care team, we also have access to a clinical nurse counsellor, social worker and dietician. We are a training practice for the South East Vocational Training Scheme for General Practitioners. We are about to begin as a “teaching practice” of the University of Limerick, taking a medical student for their community-based clinical learning.

Prior to the CRSA
We had a CRSA in 2011. While there was some level of trepidation at the outset, everyone wanted to grasp the opportunity, and was willing to participate and be open in their communications. We are normally focused on individual consultations and we welcomed the “outside view” of our processes and procedures. Prior to the visit, the practice completed a short questionnaire, providing background information, and each member of staff completed a confidential patient safety survey.

On the day
We started with a selection of one-to-one interviews with a cross section of staff, and then we closed the practice for an afternoon, with a skeleton staff providing emergency cover, while everyone else went to a workshop.

We formed cross-functional groups and started discussions. We were amazed at the issues that were identified, often from our own experience that had not been captured previously. It was an eye-opener for some of the technical areas, where we assumed we were compliant but in fact found we may not be!

The passion of the participants, the ease of communications and the accuracy of their observations were energising. It was a very positive experience. We all wanted the same objective for our practice and patients, but prior to this we had few opportunities to process or capture these learning opportunities.

What’s different now?
The CRSA identified a number of areas for attention and we are working our way through the list. We have addressed many of the areas identified and while we have made good progress we still have much to do.

- For example, we have reviewed our health and safety protocol, we have carried out the manual handling training and we have tested a fire evacuation plan.
- We have reviewed our compliance with the Misuse of Drugs Act (1977 and 1984) and the Misuse of Drugs Regulations (1988).
- We have completed some clinical and administrative protocols, eg, vaccination, interruption, Did not Attend patients etc, and are working to document as many as possible of our procedures, have them approved and signed and available on the system for all staff to access. This will also be the source for training of new employees.
- We will also track revisions to policies and procedures, as required, so that the documents remain up-to-date.
- We have created a schedule of meetings, (clinical, administrative and practice-wide) to facilitate the flow of ideas and learning opportunities. We have changed the practice opening times to facilitate this schedule.
- We are targeting our training activities to meet real needs, and are encouraging training requests from staff.
- We are extending and remodelling our premises and the recommendations are being incorporated into the design, eg, the reception area is being designed to facilitate patient confidentiality, and there will be an area for the storage of full sharps boxes awaiting collection.

In summary, we now have a better structure to address learning opportunities. We are working on written policies and procedures, we actively foster better communications, and there is a heightened awareness of risk. Staff are empowered to draw attention to issues as they arise, so that they can be addressed promptly.

We always had good intentions, but now they are better supported by systems. Identifying and sharing learning opportunities has given everyone a voice and an understanding that preventing errors is everyone’s responsibility. We expect this will lead to better outcomes for all.

WHAT HAPPENS AT A CRSA?

Before the visit:
- A questionnaire is completed to provide MPS with a snapshot of your practice.
- There will also be a staff survey of patient safety culture, to help identify the importance attached to patient safety.

The visit:
- A full day visit by a trained risk assessment facilitator.
- Confidential discussions with key members of staff to gain an insight into working practices and perceived risks.
- An educational session for all practice staff providing an explanation of risk management and its importance, the purpose of the visit and discussions of potential risks.

After the visit:
- An action plan is produced by the MPS facilitator containing summaries of the main findings and anonymised feedback from the staff survey. The action plan can be continually used within team meetings to review progress.

How to book a CRSA
- The full price for a CRSA is €2,100. Significant discounts are available based on the number of MPS members in your practice, for example: if approximately 80% of GPs in your practice (minimum of two GPs) are MPS members, you will be entitled to a CRSA FREE OF charge, as a benefit of membership.

For further information or to book telephone: +44 (0)113 241 0624, email: crsa@mps.org.uk or visit: www.medicalprotection.org/ireland/crsa-gp
A Monday morning in your surgery might start off simply enough: Mrs M, the receptionist, is faxing a number of referral letters and patient information through to the local hospital. Midway through punching in the number for the orthopaedic department, the phone rings and Mrs M answers: an elderly patient requires an emergency home visit. She takes the message whilst finishing off sending the fax. When she puts the phone down, she suddenly realises she has typed in the wrong number – and sensitive patient information has been sent to the wrong address.

MPS has dealt with a number of cases where information has been picked up by the wrong person, often because of misdialling or out-of-date fax numbers. This can mean that patient confidentiality is breached and treatment is delayed, due to the time lapsed until the information reaches the correct person.

You have a moral and ethical duty to ensure that data relating to an identifiable individual is held securely. In accordance with the Medical Council’s A Guide to Professional Conduct and Ethics for Registered Medical Practitioners (2009), all doctors have a responsibility to ensure that any data about patients is kept secure. Doctors should also make sure that, if sensitive information needs to be sent electronically, safeguards are in place to avoid breaching patient confidentiality.

For further information see:
- MPS factsheet, Communicating with patients by fax and email, 2010 www.medicalprotection.org/ireland/factsheets/communicating-with-patients-by-fax-and-email
- Health Information and Quality Authority, General Practice Messaging Standard, 2011 www.hiqa.ie

Data Protection Commissioner, www.dataprotection.ie
Irish College of General Practitioners, A Guide to Data Protection Legislation for Irish General Practice 2011 (7.1.5, Use of Fax Machines) www.icgp.ie/go/in_the_practice/information_technology/data_protection
ICGP Fax Referral Security Concerns: www.icgp.ie/index.cfm?spKey=in_the_practice.it_faqs.managing_information&spId=DDD275EF-19B9-E185-83A819ACC302CB58&highlight=fax
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MPS  Putting members first

We are committed to helping members avoid problems
and provide the best care for patients.

We hope you find this publication useful
and would welcome your feedback.

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