Professional support and expert advice for GP partners and practice managers

Medical Protection

Practice MATTERS

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LISTENING TO COMPLAINTS

The President of the Medical Council on what GPs can learn from its review of complaints

INSIDE...

EDITORIAL TEAM

Dr Sonya McCullough EDITOR-IN-CHIEF 

Sam McCaffrey EDITOR 

CONTRIBUTORS
Dr Rachel Birch, Diane Baylis, Jack Kellett, Kate Taylor, Rachel Lynch

DESIGN
Emma Senior, Allison Forbes, Conor Walsh, Lucy Wilson

PRODUCTION MANAGER
Philip Walker

MARKETING
Rachel Lynch, Peter MacDonald

EDITORIAL BOARD

Dr Muiris Houston PROFESSOR OF MEDICAL HUMANITIES 

Antony Timlin HEAD OF CORPORATE COMMUNICATIONS 

PRACTICE MATTERS IRELAND
Victoria House
2-3 Victoria Place
Leeds LS11 5AE
United Kingdom

Please direct all comments, questions or suggestions about MPS service, policy and operations to:

Chief Executive
Medical Protection Society
33 Cavendish Square
London W1G 0PS
United Kingdom

chief.executive@medicalprotection.org

In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

UK medicolegal advice
Tel 0800 561 9090
Fax 0113 241 0500
querydoc@medicalprotection.org

UK membership enquiries
Tel 0800 561 9000
Fax 0113 241 0500
member.help@medicalprotection.org

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What's INSIDE...

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

MEET YOUR REGIONAL MEMBERSHIP CO-ORDINATOR: RACHEL LYNCH

Rachel has worked in the Marketing Department at Medical Protection for more than ten years:

"I regularly visit medical schools and hospitals to talk to members and arrange medicolegal events for some of the professional organisations in Ireland, including the Royal Colleges.

"If you would like a visit to talk about your membership, or you are organising a teaching event, training day or conference, then you can contact me to help arrange sponsorship or a speaker."

Contact her on 087 2867491
Rachel.lynch@medicalprotection.org

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FEATURE

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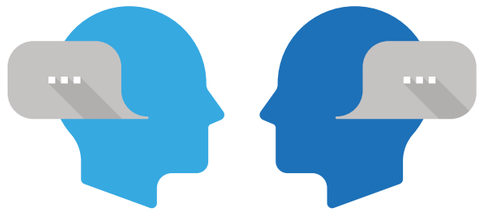

WELCOME

As the festive season approaches it is easy to get swept up in the excitement and forget about the risks it brings, along with those of everyday practice. This edition of *Practice Matters* highlights some of the risks unique to this time of year on page 22 in 'The 12 Risks of Christmas', while we also look at issues that are relevant all year round in our collection of the Top General Practice Questions on page 8.

We are also delighted to have a contribution from Prof Freddie Wood, President of the Medical Council, in this edition. He writes about the Council's recent review of complaints and what GP's can learn from it on page 6.

Meanwhile on page 16 you will find a helpful step-by-step guide on the use of chaperones during intimate examinations, we encourage you to cut it out of the magazine and stick it up somewhere you can refer to whenever the use of a chaperone might be relevant.

It has been conference season for the Medical Protection team so this edition also includes round ups from our very own General Practice Conference as well as the ICGP Network of GP Trainees Conference.

We hope you enjoy this edition. As always we welcome feedback so please get in touch with any suggestions.

Dr Sonya McCullough – Editor-in-Chief

COMMUNICATING WITH PATIENTS BY TEXT MESSAGE

Various text messaging services are being used by practices in order to notify patients of appointments, flu vaccinations etc. Although a quick and simple process for both patient and practice, there are medicolegal issues to consider with this method of communication.

Patient consent must be obtained prior to communicating by text message. In many cases you may already have the patient's mobile phone number but this does not necessarily mean they want you to contact them in that way.

Be sure to revise the information contained in text messages; in general terms, text messaging lends itself to sending out generic reminders to specific target groups. However, it is not an appropriate way to deal with clinical queries and patients should be made aware of this.

The content of each text message must be generic and only include essential information. It is unnecessary to state the nature of the appointment or any personal details other than the date and time of the appointment – providing any further information may be seen as an indiscreet disclosure.

The text message should be considered part of the patient's medical records and therefore consent to communicate by text message must be recorded in full, as well as the date, time and content of any messages sent to the patient. Any response received should also be recorded.

For more advice on communicating with patients by text messages, please visit the factsheet section of our website.

USE OF SOCIAL MEDIA

Social media channels offer many new opportunities to communicate with patients. Many of these channels also represent effective outlets to promote healthcare, but they also present many new challenges for healthcare professionals.

Patient confidentiality is a key issue – the very public nature of social media means doctors must take care to avoid unintentional disclosures. A doctor's professionalism also faces new challenges when communicating via social media, as any comments made relating to patients, colleagues or employers can be unintentionally published to a wider audience.

Bearing these issues in mind, the Irish Medical Organisation (IMO) has published a Position Paper on Social Media that establishes guidelines on the use of social media and other interactive online applications. As well as the IMO's guide to using social media, the organisation you represent may also have their own policies on proper usage, which you must be aware of.

The IMO advises: "You should always be mindful that the content you generate on sites can reach a public domain regardless of your intention for the information to be public or private. If any content you post leads to the identification of the patient without their consent it may be considered to be a breach of confidentiality."

For more advice on the use of social media, please visit the factsheet section of our website.

To read these factsheets, and see what other ones Medical Protection has to offer, visit:

medicalprotection.org/ireland/resources/factsheets

Follow us on Twitter

Good news for those who like to be kept up-to-date whilst on-the-go – Medical Protection is now on Twitter! If you use Twitter in a professional capacity, why not follow @MPSdoctorsIRE?

LISTENING TO COMPLAINTS

In July the Medical Council published its first ever comprehensive review of complaints. Professor Freddie Wood, President of the Medical Council, spoke at the Medical Protection Consultant Conference earlier this year about what was learned from this review, and he now writes for Practice Matters on what GPs can take away from it.

The doctor–patient relationship is an absolutely inherent aspect of patient care. It is critical that a good relationship is in place, especially for those who are feeling vulnerable, as they require a heightened reliance on the physician's competence, skills, and compassion. Today, patient satisfaction is more important than ever as patients expect to experience safe, high quality and satisfactory care from doctors they trust are engaged in good professional practice. I am pleased to say that this, for the most part, seems to be the current situation in Ireland. Studies conducted by the Medical Council have demonstrated that over nine-in-ten people trust doctors and that 94% of people were satisfied with the care they received from their doctors; furthermore, nine-in-ten people have never had an experience with a doctor which led them to consider making a complaint.

We see from this data, that the patient-doctor relationship in Ireland is, for the most part largely positive, but it is vital we do not take this for granted. Sometimes, the care patients receive from their doctor does not meet their expectations which may, in turn, lead to a complaint being made to the Medical Council. It goes without saying that the medical profession is extremely risky and outcomes are far from certain. It is the Medical Council who has the statutory duty to safeguard the public by investigating, and subsequently dealing with these complaints, which can often be a very difficult and long-drawn out process for all involved.

I know from experience that many doctors shudder when they hear the term 'fitness to practise inquiry'. They see it as a purely punitive process; a public experience of trauma and distress. I for one understand this, as I was once censured by the Medical Council. As a profession, we should accept that complaints will happen. We should not be afraid of them, but look at them as an opportunity to learn and prevent a similar situation from happening in the future. If we take that approach in handling concerns that arise, in many cases, this would lead to a successful resolution. That is why, as president of the Medical Council, I feel I have a responsibility to work with my colleagues to inform the profession on the complaints process to a greater degree. We as an organisation want to support a strong patient-doctor relationship and encourage doctors to take responsibility for self-regulated practice.

We launched our Statement of Strategy in 2014, and one of the fundamental objectives in the strategy is to enhance patient safety through research and greater engagement. We have made it a priority to inform our own work and that of the wider health system through the provision of information and research. It's important that we are constantly learning and that the system encourages this learning at all levels. In setting ourselves this aim we asked ourselves how we can provide leadership through our role in dealing with complaints, and therefore we decided to carry out a review of complaints submitted to the Medical Council over a five-year period.

The *Listening to Complaints, Learning for Good Professional Practice*[1] report represents the first time that the Medical Council systematically reviewed complaints it has received about doctors. A mixed method approach was used to produce this report combining quantitative and qualitative methods in order to describe the trends in complaints and identify factors which cause concern among complainants. The quantitative review looked at the likelihood of complaints, and doctor related factors, the source of complaints and linkage with outcomes and the likelihood of "higher impact" or more serious disciplinary decision-making. The qualitative review was both rich and comprehensive and gave us a greater insight into some of the "why" and "how" questions.

The study identified many themes which I believe are in the interest of the profession. The report enabled us to gain an insight into the type of doctors that might be more prone to having a complaint made against them. It emerged that males were twice as likely as their female colleagues to have a complaint made against them, along with specialists, older doctors, doctors who have previously been complained about and graduates of Irish medical schools. Doctors who were more prone to being disciplined at the fitness to practice stage included older males, non-specialists, international graduates and those without legal representation.

While questions about medical knowledge and skill featured in complaints, poor experience of doctors' attitudes and behaviours commonly motivated complainants. Common factors for causes of complaints were a lack of communication and compassionate behaviour between doctors and their patients, a failure to treat patients with dignity and respect and a failure to effectively deal with patients' families. It was also particularly interesting to note that communication and compassion were not simply perceived as a "bonus" by patients, but an absolute inherent part of the patient-doctor relationship. This shows that good communication is key and should never be taken for granted.

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The report also found that some work contexts presented more complaint-prone environments than others. Psychiatrists, cosmetic surgeons, obstetricians and gynaecologists and locum/out-of-hours were those who were more at risk. This finding may prompt doctors within these specialities to be particularly mindful in their dealings with patients.

This piece of research provides an abundance of learning for both the Medical Council and the profession and in my opinion it is one of the most significant pieces of research conducted by Council to date. It is also beneficial to our partner organisations within the healthcare sector. This includes medical defence organisations such as Medical Protection who are doing some great work to use research such as this to inform and educate doctors on what makes some members of the profession more 'at risk' than others.

As one might expect, most complaints to the Medical Council within these five years (2008-2012) came from members of the public. Only 3% of complaints came from the HSE and other employers. Interestingly, but perhaps not surprisingly, our research shows that complaints made by employers and other healthcare professionals were more likely to proceed to inquiry. This and the fact that the majority of complaints do not warrant further regulatory action demonstrates the need for a more effective complaints system at a local level so that members of the public can be more assured in raising their concerns locally, where a satisfactory outcome could be achieved for both parties before needing to recourse to the medical regulator. If there was a focus on welcoming, addressing and learning from complaints at every hospital or practice in Ireland the number of complaints being made to the Medical Council would undoubtedly decrease, meaning these less serious complaints could be resolved in a more appropriate and low-key manner for the benefit of both the complainant and the doctor who is subject to the complaint.

At the Medical Council our aim is no longer to just regulate the profession, we seek to set standards and provide leadership while encouraging doctors to act in the best interests of their patients. Since the beginning of my term as Council President, I have made it my mission to inform our work and that of the wider health system through the provision of such research. I hope that by reflecting on the findings of this report and looking at the most common themes or causes of complaint, we can work together to reduce such instances occurring in the first place for the benefit of patients, doctors and the healthcare system as a whole.

Poor communication is a key problem identified in the majority of patient complaints. Medical Protection offers a range of free, CPD accredited workshops, including Mastering Difficult Interactions with Patients, that seek to address this. To find out more and sign up go to: **medicalprotection.org/ireland/education-and-events/**

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To view all Medical Council publications go to: **medicalcouncil.ie/news-and-publications/publications/**

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ICGP NETWORK OF GP TRAINEES CONFERENCE 2015

This year's ICGP Network of GP Trainees Conference in October marked 10 years of Medical Protection sponsoring the event. Rachel Lynch reports from the conference.

The increasing numbers of newly qualified GPs who are planning on leaving Ireland to practice elsewhere was a hot topic at the ICGP Network of GP Trainees Conference, which took place in the Lyrath Estate in Kilkenny on 15 and 16 October.

An ICGP survey earlier this year revealed that only a third of trainee GPs 'definitely' plan to stay in Ireland when they complete their specialist training. It also showed that substantial numbers find the financial and employer responsibilities of being a principal or partner GP unattractive.[1]

The conference was opened by ICGP CEO Kieran Ryan, who welcomed all of the attendees. He went on to mention all of the challenges facing general practice in Ireland, however his speech was positive in the main as he spoke about new GPs shaping the future and referred to the recent IMC report that GP Trainees are generally a satisfied group.

The keynote address was delivered by Medical Protection member, and TV doctor, Dr Ciara Kelly.

A wide variety of topics were covered at the conference, including the importance of self-care for doctors, how GPs can support marginalised groups, anatomy, skin surgery in general practice and HIV testing. Several speakers spoke about MICGP exam preparation and Patricia McQuillan ran a session on the evolving role of practice nurses in Irish general practice.

GP trainees from all over the country attended the Network of GP Trainees Conference as Medical Protection celebrated ten years as sole sponsors of the event.

It also marked the first time the event was entirely organised by the Network of Trainees themselves as opposed to the ICGP.

Dr Rukshan Goonewardena, a member of the organising committee, said: "Trainees value having an event dedicated to their education needs and enjoy getting an opportunity to network with colleges and members of the ICGP. The conference this year was a great success with over 250 trainees attending. The organising committee would like to thank Medical Protection for the education grant that made this event possible."

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1. Dr G Mansfield et al, Bridging the gap – How GP trainees and recent graduates identify themselves as the future Irish general practice workforce, ICGP (2015)

NO 'I' IN TEAM

Diane Baylis, Clinical Risk and Education Manager at Medical Protection, explains why effective teamwork in general practice is so important.

Having a good team is vital for success in many aspects of life. Sport and business provide many excellent examples of teams working well together while enjoying a culture of success. With this in mind, how can effective teamwork translate into general practice where established attitudes about autonomy and cooperation add to the complexity of providing care?

Other industries, such as aviation, have improved their reliability by applying innovative concepts to interpersonal relationships and hierarchical structures. A similar approach may assist general practices, which often employ many members of staff, to work together as a team in order to attend to the needs of their patients and provide them with the best service possible. The importance of teamwork and its impact on effective outcomes may therefore be even more prominent in the healthcare sector than in other sectors.[1]

NATIONAL STANDARDS FOR SAFER BETTER HEALTHCARE

The National Standards for Safer Better Healthcare have been developed by the Health Information and Quality Authority (HIQA).[2] These National Standards apply to all healthcare services (excluding mental health) that are funded by the HSE, including general practice. Although HIQAs' authority does not cover private healthcare, it is anticipated that private healthcare providers will also adopt these standards in preparation of future statutory licensing. Theme 5 (in the standards) relates to leadership and the promotion of a culture of quality and safety. The delivery of high quality, safe and reliable healthcare not only involves teamwork but good communication, leadership and adopting a culture where healthcare professionals can discuss patient safety openly amongst the team and with the patients themselves. In order to achieve this, a positive approach to teamwork is required.

Medical Protection has developed a Safety Culture 360[3] tool, available on our website, to assist practices to survey the safety culture in their practice, in order to increase staff awareness and ensure a positive and measurable difference to patient safety.

CHALLENGES

Practice teams are diversifying and as a result, communication and teamwork is becoming increasingly challenging. The face of general practice has evolved over recent years with the introduction of new roles and responsibilities, as well as more traditional duties. This is particularly evident in large teams that encompass a wide variety of very different individual roles. While this makes teamwork and communication difficult, never has it been more important to get it right.

TEAM MEETINGS

One crucial factor for effective teamwork is team meetings. Regular team meetings have been linked with greater levels of innovation and effective teamwork.[4] Similarly, failure to set time aside for team meetings is believed to have a negative impact on team building and communication.[5] Given that many staff work part time, team meetings are also particularly important for the dissemination of information.

Despite this, setting time aside for a multidisciplinary team meeting on a regular basis is inconsistent throughout general practice in Ireland. General practice is under constant pressure and time is often stated as the reason why teams do not have the opportunity to have team meetings.

Medical Protection undertake Clinical Risk Self Assessments (CRSAs)[6] of general practices in the UK and Ireland. Risks in the practice are identified and given a risk rating, and added up to produce an overall risk score for the practice. Of the practices, in 2014 who underwent a risk assessment, a distinct correlation was found between practices that had a very high risk score and a lack of regular multidisciplinary team meetings. On the other hand, it was found that of the practices that had a low risk score, the majority (94.2%) of them were undertaking regular multidisciplinary team meetings. The practices that had the lowest risk score also had better systems in place for communication within the team. The value and benefits of regular team meetings are therefore apparent from these figures.

BENEFITS

Staff who feel that they have organisational support generally have a greater sense of commitment to their role. Organisational support and reward is important for team members to feel valued and motivated, and a strong sense of team spirit can also greatly enhance job satisfaction. In turn, this increases staff retention, which is particularly important in general practices where many now struggle to recruit experienced staff.

OVERCOMING BARRIERS

In general practice, one of the barriers to developing a cohesive team is a perceived hierarchical structure. Therefore, barriers between professional groups such as doctors, nurses and administrative staff can have an influence on teamwork. This can often inhibit some team members from participating in decision making and providing open input in team meetings. Having regular meetings leads to breaking down inhibitions, promotes positive interpersonal relations and encourages involvement for some of the more junior members of the team, who are often less likely to contribute.

Given the current climate in healthcare, where litigation against healthcare professionals is rising, safety is of paramount importance. Healthcare professionals and general practice teams are more aware of the importance of clinical risk management and the need for a positive safety culture. The implementation of regular team meetings not only improves the culture of the organisation and teamwork, but it also has a positive impact on patient safety and improves communication within the multidisciplinary team.

To find out more about Safety Culture 360, and what other risk management tools we have to offer, please visit: medicalprotection.org/ireland/education-and-events

CASE STUDY

After attending a CPD workshop on infection control with Medical Protection[7] a GP was concerned that his practice might not be compliant with current regulations, so he asked the practice manager to put this on the agenda for the next practice team meeting. The practice held a monthly team meeting that was attended by all staff: doctors, nurses and reception/non-clinical staff.

Nurse D, who was the practice lead for infection control, had recently reviewed the practices infection control policy to ensure that it was compliant with current guidance. She presented the reviewed policy to staff at the team meeting, ensuring that they were all aware of key areas and responsibilities, as well as any changes in the policy.

Nurse D felt reassured that the team meeting had facilitated the reinforcement of good infection control practices to the team and that they were aware of the practices' policy. The team also had the opportunity to discuss any infection control issues and concerns that they had. Minutes were taken and disseminated to those members of the team that were not at the meeting.

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TOP GENERAL PRACTICE QUESTIONS

Medical Protection receives queries from GPs and practice managers every day on wide range of different issues; however some topics are more common than others. Here is a list of the top problem areas in general practice that might cause you concerns.

TRIAGE FOR NON-CLINICAL STAFF

The quality of assessment undertaken by the receptionist, who may be a relatively junior member of staff, is crucial to deliver safe and effective urgent care. The challenge is to correctly identify, and rapidly respond to, the tiny number of patients in whom a delay will result in harm, or possibly even death. Have you identified and discussed these emergency situations? Have you a simple procedure for receptionists to follow when these rare situations arise? To rely on the common sense of receptionists to identify rare situations, and hope they respond appropriately, may pose an unacceptable risk to patients, staff and clinicians.

Identification and initial management of emergencies by reception staff depends on three key components:

i. A framework to identify emergencies
ii. Training for receptionists
iii. Analysis and feedback

Medical Protection has developed a triage protocol for non-clinical staff that you are free to use. To access it search for 'Triage Protocol' on our website.

INFECTION CONTROL

Medical Protection undertakes Clinical Risk Self Assessments (CRSAs) of general practices, which are a systematic approach to identifying risks and developing practical solutions to ensure quality practice and prevent harm to patients. Data collected from 107 CRSAs conducted across the UK and Ireland during 2014 revealed that 71% of practices had issues with infection control.

Medical Protection has recently launched Infection Control 360, a new online tool designed to ensure your practice is doing all it can to protect patients from unnecessary illness and to meet the requirements of the Health and Social Care Act. It will help you to understand where your practice is performing well and highlight opportunities for improvement. To find out more search 'Infection Control 360' on the Medical Protection website, or email: crsa@medicalprotection.org

In addition Medical Protection offer an infection on site risk assessment and infection control workshop for your practice team. Please visit our website for further info:

medicalprotection.org/ireland/infection-control

REPEAT PRESCRIBING

Studies have shown that one in eight patients has prescribing or monitoring errors in their repeat prescription. Extra care must be taken when repeat prescribing, especially if you were not the original prescriber and have not seen the patient.

Patients, practice staff, GPs and pharmacists all have a role to play to minimise error. Hospital prescriptions add a further layer of complexity and enormous potential for serious error. Safe repeat prescribing is everyone's responsibility but, ultimately, the doctor that signs the prescription is legally responsible for it.

To safeguard against any problems:

- where possible, try and arrange for repeat prescriptions to be signed by a doctor who sees the patient regularly
- set time aside for signing repeats, allowing time to check the patients' records
- make sure acute prescriptions do not get mixed in with the repeat prescribing pile.

For more information on the risks in repeat prescribing for GPs please visit:

medicalprotection.org/ireland/resources/factsheets

PRACTICE NURSES AND ANTENATAL CARE

If you, as a GP, employ a practice nurse you must ensure the nurse has appropriate and adequate professional protection for their own acts and omissions. The benefits of GP membership do not include protection for your vicarious liability for the nurse.

Practice nurses and nurse practitioners who are employed by a Medical Protection member (or their practice) can apply for membership of Medical Protection.

Medical Protection does not provide membership for the provision of midwifery services. However, membership does extend to practice nurses participating in basic antenatal care including weight measuring, blood pressure and urinalysis.

Medical Protection membership does not extend to practice nurses undertaking the assessment of foetal growth, presentation, viability or scanning, or postnatal care.

The Medical Protection website has Factsheets on a wide range of general practice topics. To see if they have the answer to your questions go to:

medicalprotection.org/ireland/resources/factsheets

RISK ALERT
NURSES AND DELEGATION

Medical Protection Clinical Risk and Education Manager Kate Taylor shares tips on how to decrease risks associated with delegation.

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Within a climate of stretched resources and increasing demands on general practice, practice nurses are taking on more patient care that traditionally would have been managed by GPs. This means that in an increasingly litigious environment it is important to be aware of the risk management issues relating to delegation, nurses professional responsibilities and accountability.

ACCOUNTABILITY

The Nursing and Midwifery Board of Ireland (NMBI) and Medical Council are clear in their respective guidance for nurses and doctors that practitioners have a duty of care and a legal liability with regard to patients.

According to the Medical Council's *Guide to Conduct and Ethics for Registered Medical Practitioners*: "If you delegate tasks to doctors in training, you are still responsible for making sure the task is carried out safely and competently."[1]

This principle can be extended to nurse practitioners, nurses and other healthcare colleagues. If a GP or a registered nurse delegates a task they must ensure that the task has been appropriately delegated, meaning;

- the task is necessary and delegation is in the patient's best interest
- the nurse or support worker delegated the task understands the task and how it is to be performed
- the nurse or support worker has the skills and abilities to perform the task competently
- the nurse or support worker accepts the responsibility to perform the task competently.

Both the NMBI and the Medical Council are clear that when you delegate care you are still responsible for the overall management of the patient.

Within general practice it is the responsibility of the employing GP partners to ensure that all clinical tasks are delegated to employees who have the appropriate education, training and skills to carry out those tasks delegated to them.

PROFESSIONAL RESPONSIBILITIES OF NURSES

The NMBI *Code of Professional Conduct and Ethics* summarises the accountability of a nurse delegating a task:

"You are accountable if you make a decision to delegate a nursing or midwifery task to someone who is not a registered nurse or midwife.

"If you delegate tasks or roles, you should provide comprehensive and effective assessment and planning, communication, monitoring and supervision, and evaluation and feedback."[2]

Translating this to general practice means ensuring practice teams have appropriate systems and processes in place to safeguard the delegation of any nursing activities.

Each individual nurse will adopt his/her own safeguarding processes prior to delegation; however it is useful to consider a structured approach. The Royal College of Nursing in the UK has useful guidance on key questions to consider when delegating to another member of the team:[3]

- Is the delegation in the best interest of the patient?
- Is the person you are delegating to suitably trained and have they been assessed as competent, preferably with written evidence of the assessment?
- Are there clear and robust protocols and guidelines in place?
- Does the task form part of the member of staff's job description?
- Do the members of the team know this task has been delegated?
- Is there sufficient supervision and support available?
- Is ongoing training and development available to ensure the member of staff remains competent.
- Has a risk assessment been undertaken?

INDEMNITY

As nurse roles grow in scope, claims against nurses have increased. It is therefore important that nurses are on the correct grade for the work that they undertake. The NMBI also states that nurses should ensure they are adequately indemnified.[2]

Medical Protection offers associate rates which are only available to nurses employed by Medical Protection members.

The three rates available are:
- Nurse Practitioner
- Practice Nurse
- Phlebotomist

Nurses working in urgent or out of hours care should contact Medical Protection to discuss their membership.

It is possible that clinical negligence claims are made against the practice as a result of the negligent acts or omissions of healthcare staff working at all levels; if you employ staff you should check with Medial Protection to ensure that they are adequately and appropriately indemnified.

Delegation is a professional skill requiring GPs and nurses to match patient needs with the appropriate level of skill to ensure that patient care needs are in no way compromised. The current health care system continues to work under pressures and will inevitably make the need to delegate even greater. As doctors and nurses working in general practice we must be mindful of this and ensure safe high quality patient care.

PRACTICAL TIPS FOR SAFE DELEGATION

- Ask is the delegation appropriate?
- Identify any training needs
- Identify support available
- Following training, assess competencies in relation to knowledge, skills and experience
- Ensure robust quality assurance for example by peer review, performance review
- Ensure that the practice has a system for reporting if things go wrong to include the sharing of lessons learnt with the whole practice team
- Ensure that all health care professionals have appropriate indemnity arrangements
- Ensure a robust practice protocol in place for any delegated tasks including when to escalate and refer onto a more senior member of the practice team.

CASE STUDY

Patient X had been visiting the practice nurse three times a week for the management of a burn that she sustained to her left leg following an accident at home. Patient X's wound was healing slowly but was showing signs of improvement therefore the practice nurse thought it appropriate to delegate future dressing changes to the health care assistant (HCA).

Subsequent dressing changes were managed by the HCA. Some weeks later the HCA was on holiday and so Patient X was seen by the practice nurse. As she began to remove the dressing the practice nurse noted an odour from the wound and that the dressing was particularly wet with exudate. On completely removing the dressing she discovered that Patient X's wound had deteriorated considerably. The practice nurse re-assessed the wound and determined that it was probably infected; she took a wound swab and asked the duty doctor to review it. Patient X was started on a broad spectrum antibiotic. The practice nurse redressed the wound and advised Patient X that she would now need daily dressings until an improvement was noted.

The practice nurse documented her findings, assessment and treatment plan in Patient X's medical notes. At this point she also noted that the HCA's documentation of previous dressing changes was sparse with no reference to the deterioration of the wound.

Patient X completed the course of antibiotics and within a few weeks the wound was completely healed. The practice nurse recorded the incident as a significant event and a subsequent investigation revealed the following learning points;

The practice nurse failed to assess the HCA's competency in wound care

The HCA had not had specific training in wound management

The practice nurse had not written an appropriate care plan for the wound management detailing when the HCA should seek further support or advice

The HCA had inadequate support from the practice nurse, several weeks had gone by without a review of the wound by a registered nurse

The HCA medical records were inadequate, identifying that the HCA had not undergone any specific training in medical records

Discussion at the practice team meeting raised the issue as to whether this had been an appropriately delegated task.

FIND OUT MORE

To help protect our members we provide ongoing learning and development opportunities to help you avoid complaints, claims and litigation.

To find out more, visit: medicalprotection.org/ireland/education-and-events

REFERENCES

1. Medical Council, Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 2009
2. Nursing and Midwifery Board of Ireland(NMBI), Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives, 2014
3. Royal College of Nursing (RCN), Accountability and delegation: what you need to know, 2011

USING CHAPERONES IN GENERAL PRACTICE

This flowchart provides a step-by-step guide for doctors in the use of chaperones during intimate examinations.

The Medical Council, in *A Guide to Professional Conduct and Ethics,* states that: "Clinical assessment of a patient often involves a physical examination as well as relevant history-taking. You should explain what this examination will entail and seek permission from the patient before making a physical examination.

"Where an intimate examination is necessary, you should explain to the patient why it is needed and what it will entail. You should also let the patient know that they can have a chaperone present if they wish."

Obvious examples of intimate examinations include those of the breasts, genitalia and the rectum, but it can also extend to any examination where it is necessary to touch or be close to the patient; for example, conducting eye examinations in dimmed lighting, placing the blood pressure cuff and palpating the apex beat.

You should let the patient know that they may have a chaperone present if they wish. The offer of a chaperone is for the protection of both the patient and the doctor.

START

CONSENT

Before performing an intimate examination, it is important to explain what the examination will entail, why it is necessary, allow patient to ask questions and seek permission from the patient.

OFFER CHAPERONE

If the patient gives consent to examination you then ask the patient if they would like a chaperone to be present.

PATIENT REJECTS CHAPERONE

If the patient rejects the offer of a chaperone but you do not wish to continue without one you should:

- Explain why you want a chaperone present.
- If the patient still declines the patients clinical need takes precedence, consider:

Would delay affect the patient's health?

YES

NO

PERFORM THE EXAMINATION

The patient's wellbeing is paramount so even if you would prefer a chaperone to be present it would be prudent to still perform the examination if a delay could adversely affect the patient's health. An alternative option might be to see if a colleague is available to conduct the examination immediately.

You should record any discussion about chaperones and the outcome in the patient's medical record. If you offer a chaperone and it is declined state this clearly along with the clinical reasons why you chose to proceed with the examination.

REFER TO A COLLEAGUE?

If the delay would not affect the patients' health you might consider referring the patient to a colleague who would be more comfortable performing the examination without a chaperone present.

You should record any discussion about chaperones and the outcome in the patient's medical record.

PATIENT ACCEPTS CHAPERONE

If the patient accepts a chaperone it is important to consider who in your practice would be appropriate to act as a chaperone. The GMC guidance on intimate examinations and chaperones states that a chaperone should:

- Be sensitive and respect patient dignity and confidentiality
- Reassure the patient if they show distress
- Be familiar with the procedure
- Stay for the whole examination
- View the examination (if possible)
- Be prepared to raise concerns if they witness anything inappropriate

The relative or friend of a patient is not an impartial observer and cannot serve as a chaperone.

Is a suitable chaperone available?

NO SUITABLE CHAPERONE

If a suitable chaperone is not available you should consider delaying the examination until a suitable one can be present.

In making this decision you should consider:

Would delay affect the patient's health?

YES

NO

DELAY THE EXAMINATION

If the delay would not affect the patients' health you might consider delaying the examination until a suitable chaperone is available.

You should record any discussion about chaperones and the outcome in the patient's medical record.

SUITABLE CHAPERONE AVAILABLE

If the patient accepts a chaperone and a suitable one is available you should proceed with the examination.

During the examination the chaperone should be present and in a position to observe the examination.

PRIVACY

Give the patient privacy to undress and dress, and keep them covered as much as possible to maintain their dignity; do not help the patient to remove clothing unless they have asked you to, or you have checked with them that they want you to help.

THE EXAMINATION

While conducting an intimate examination you should:

- Explain what is about to happen before doing it, each step along the way.
- If this differs from what you previously told the patient explain why and seek permission
- Stop the examination if a patient asks you to
- Keep discussion relevant and don't make unnecessary or inappropriate comments

PERFORM THE EXAMINATION

Explain the situation to the patient, including why you feel it is necessary to carry out the examination without waiting for a chaperone.

After the examination you should record any discussion about chaperones and the outcome in the patient's medical record, make sure to specify clinical reasons for performing the examination without a chaperone present.

AFTER THE EXAMINATION

Following the examination the patient should be given privacy to dress if required. The chaperone should leave and you should then discuss the findings of the examination with the patient.

You should record any discussion about chaperones and the outcome in the patient's medical record. If a chaperone is present, you should record that fact and make a note of their identity.

Information for this flowchart was taken from the *GMC Intimate Examinations and Chaperones* 2013 as there is no current guidance available in Ireland.

GENERAL PRACTICE CONFERENCE 2015: SPOTLIGHT ON RISK

The fourth annual Medical Protection GP Conference was held on 3 October at the Convention Centre in Dublin. Jack Kellett reports on the events of the day.

Change was the focus at the fourth annual Medical Protection General Practitioners Conference. The word was used from the offset in a keynote address from Dr Peter A Sloane, President of the Vasco da Gama Movement (VdGM) and Director of the ICGP Network of Establishing GPs, as he described the changing landscape of general practice in Ireland and the challenges facing both practitioners and patients.

The advancements in digital and IT capabilities also played a key role. Medical Protection Senior Medicolegal Adviser Dr Angelique Mastihi highlighted the growing over-reliance on IT systems to prescribe for patients as a risk in her talk on medication errors and safe prescribing.

Dr Mastihi told the delegates about a study in Ireland surveying 28 GP practices prescriptions over a three day period in 2013. In total 3,948 prescriptions were assessed and 491 (12.4%) contained one or more errors.

Of these errors 73% were found to be minor, such as a lack of adequate directions, the prescription was not signed, illegible or undated. Another 25% were nuisance errors (such as potential interactions with less serious implications). Some 2% were found to be potentially serious errors, such as an allergy, excess dose, incorrect instructions or potentially serious interaction.

Dr Mastihi went on to describe systems that can be put in place to help reduce the risk.

In another talk Dr Diarmuid Quinlan, GP and Medical Protection CRSA Facilitator, advised delegates on the risks in general practice and how to avoid a 'near hit'.

He described the current pressures general practice is facing, such as financial cuts and increasing workload, and talked about the difficulty in maintaining standards in such a climate.

Dr Quinlan stressed the importance of robust systems, telling delegates that they help to maintain standards and provide consistency.

A well designed system will include error traps so that even if an individual does make an error, it will be trapped by the system and prevented from resulting in an adverse event, he said.

Another key topic was stress and mental health experienced by doctors and the support available to them, encapsulated in the personal journey of Dr Robert Moore who told delegates about his battles with addiction.

Two hundred delegates attended the sold out event, which also included workshops that went in depth on a range of different issues, from medicolegal dilemmas to infection control to managing difficult interactions with patients.

Dr Mark Dinwoodie, Director of Education at Medical Protection, said: "There are ever-mounting pressures put upon GPs and their teams, with GPs more likely to be sued now more than ever before. In this tough environment, Medical Protection is much more than a last line of defence – we strive to be a genuine partner in your career.

"We hope that the conference has helped delegates identify key risk areas that they and their teams can focus on to make practice safer, and provided some practical advice on how to manage the risks, and safeguard members and patients during challenging times."

FROM THE CASE FILES

PRESCRIBING CONTRACEPTION TO MINORS

Medical Protection regularly receives requests from GPs for advice on prescribing contraception to minors. Editor-in-Chief and Medicolegal Adviser Dr Sonya McCullough shares a recent case and the advice that was given...

Patient Y, a 15 year old girl, attended her GP, Dr A, for advice regarding contraception. During the consultation she disclosed that she was sexually active and enquired about the contraceptive pill. Dr A did not know whether he legally could prescribe the contraceptive pill to a minor, and was also concerned that he may have a legal duty to report the information that his patient was sexually active to social services. He contacted Medical Protection for advice.

THE LAW

There are two different issues in relation to this case. The first is whether Dr A can prescribe a minor the contraceptive pill.

Under section 23 (1) of the Non-Fatal Offences against the Person Act 1997, a child becomes an adult for the purposes of consenting to medical, dental or surgical treatment at the age of 16 years. Therefore, under this Act, a child under 16 years cannot consent to medical treatment. The Irish Medical Council's Ethical Guide states that where the patient is under the age of 16 years, it is usual that the parents would be asked to give their consent to medical treatment on the child's behalf. However, in exceptional circumstances, a patient under 16 might seek to make a healthcare decision on their own without the knowledge of consent of their parent. In such circumstances, a doctor should encourage the patient to involve their parents in the decision whilst bearing in mind that it is the doctor's paramount responsibility to act in the patient's best interests.

Bearing this in mind, it may be advisable to decline prescribing contraceptives to a patient under 16 without the knowledge or consent of the parents where the doctor may be not be in a position to justify this being an exceptional circumstance.

Additionally, the HSE National Consent policy states that it is usual to involve the parents or legal guardians and to seek their consent in providing a service or treatment to a minor under 16. However, if the minor seeks to make a decision on their own without parental involvement or consent, it is best practice to advise the minor to communicate with and involve their parents or legal guardians. Only in exceptional circumstances can health and social care interventions be provided without the knowledge or consent of the parents.

The second issue concerns the fact that the child under 16 is sexually active. Does the doctor have a duty to contact social services or the Gardaí?

The Criminal Law (Sexual Offences Act 2006) states that the age of consent for sexual intercourse is 17 years. It is not defence to show that the child consented. The Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Person's Act 2012) provides for a mandatory reporting requirement regarding knowledge of crimes against children or vulnerable persons. This includes sexual intercourse with a person under 17 under the 2012 Act. Failure to report such information is a criminal offence.

There is a general defence that says a GP would only be guilty if they failed "without reasonable excuse" to disclose such information. There are also a number of specific defences under the Act which are relevant to a GP. The primary defence is where the child made known her view that she did not wish for the matter to disclosed to the Gardaí. However, there is a rebuttable presumption that a child under the age of 14 does not have the capacity to form their own view. Therefore a child above this age could form their own view regarding disclosure.

It is also a defence to show that it is the view of the GP who is providing or has provided services to the child in question that the information should not be disclosed. This can only be relied on where the GP is able to demonstrate that the decision not to disclose was reached in the manner that "continues to apply the standards of practice and care" that "can be reasonably expected" of a person working in such a position.

When a minor discloses to a medical practitioner that they are sexually active the practitioner must also consider possible abuse. The Children First National Guidelines for the Protection and Welfare of Children apply to all individuals working with children to report concerns or suspicions regarding the abuse and the neglect of children to the HSE and family services.

The guidelines also state that before deciding to make a formal report the GP may wish to discuss their concerns with the HSE Child & Family Services first. This could be done on an anonymous basis in the first instance. The guidelines state that a sexual relationship between two 16 year olds, a boyfriend and girlfriend, is illegal although it might not be regarded as constituting child sexual abuse. It also details the protocols for interactions between the Gardaí and the HSE Child & Family Services where abuse is not suspected or alleged but the children are under age. In this circumstance there is a balance to be struck when dealing with situations with minors that are not necessarily abusive in nature.

The Irish Medical Council Ethical Guide states that if doctors have any concerns regarding alleged or suspected sexual, physical or emotional abuse or neglect of children this must be reported to the appropriate authorities and or the relevant statutory agencies without delay. It also notes that the doctor should inform the parents or guardians of the intention to report the concerns unless informing the parents or guardians might endanger the child. Giving information to others for the protection of the child may be a justifiable breach of confidentiality.

The National Consent policy notes that engaging in sexual acts with a child under 17 may constitute a criminal offence and efforts should be made to involve the parents in consultations and decision making. It also notes that the health professional must be aware of any legal requirements to report sexual activity of a minor under 17 to either the Gardaí or the HSE under the Children First Guidelines.

MEDICAL PROTECTION ADVICE

As you will note from the above in Irish law a person less than 16 cannot consent to medical treatment and it would be therefore advisable for Dr A to encourage Patient Y to consult with her parents. Only in exceptional circumstances should a healthcare decision be made by a patient less than 16 years on their own without the knowledge or consent of the parents. Dr A therefore in that circumstance would need to make a very careful assessment, document carefully any discussions and justify his reasoning for providing contraception to a child under 16 in exceptional circumstances. In relation to suspected abuse of a child Dr A would need to have a detailed discussion with the patient and consider whether this is a matter that needs to be reported to the Gardaí or HSE Child & Family Services. There is the opportunity for Dr A to discuss his concerns with the HSE first before making any report.

MEDICOLEGAL

THE 12 RISKS OF CHRISTMAS

"On the first day of Christmas my practice manager said to me..." Christmas can be a challenging time in general practice. Dr Rachel Birch, Medicolegal Adviser, advises on how to survive the festive season.

"12 PATIENTS WAITING..."

With staff on holiday and the practice closed for several days over the festive fortnight, there may be a great demand for appointments. Patients often wait to attend their own health centres rather than the out-of-hours service.

- Ensure you have sufficient time to plan the staff rotas and consider making contingency plans in case of staff illness.
- Offer influenza vaccinations to all staff members.
- Make all the appointments "on the day" and ensure you have adequate time for house visits, as elderly patients may be housebound if the weather is bad.
- If you are employing locums, provide them with a good induction.

"11 FAIRY LIGHTS FLASHING..."

Whilst a well-decorated and cheery waiting room can put a smile on everyone's face, remember that there may be risks involved with festive decorations.

- Consider an artificial tree to avoid the risks of pine needles.
- When decorating the waiting room beware of trailing cables and wobbly ladders.
- Ensure you have followed the relevant safety legislation.
- Arrange for power cables and fairy lights to be checked for safety. Always use surge protector sockets.
- Ensure baubles are child friendly and not made out of glass.
- Keep any waiting room Christmas music at low volume.

"10 SENIOR PARTNERS LEAPING..."

Whilst everyone may be looking forward to the staff Christmas celebrations, remember that patients place a lot of trust in their healthcare team to look after them and behave appropriately.

- Ensure that you act professionally at all times.
- Be aware of the effects of tiredness and alcohol on performance.
- When in a holiday mood and discussing Christmas plans with patients, do not forget your duty of confidentiality.

"9 RESULTS A WAITING..."

Hospital laboratories may have a reduced collection and results schedule. This coupled with the Christmas post may lead to delays in the usual services.

- Try to make referrals electronically, where possible, from mid December, so that they are not subject to postal delays.
- If a test result is essential, request it urgently so that it is phoned back to the practice the same day.
- Arrange for important tests, such as INRs, to be done a few days before the long holiday period.

"8 MAIDS A MILKING..."

It can be fun to bring in 'treats', but make sure that you follow some basic rules to ensure the staff don't all become the patients.

- Check the sell by date on the milk.
- Ensure you follow basic food hygiene rules and do not reheat food more times than is recommended.
- If the cleaning staff are on leave take extra care to wipe surfaces with antibacterial fluids and do the washing up promptly.

"7 NOTICES INFORMING..."

It is surprising how many patients do not consider the altered surgery opening hours until it is upon them.

- Advertise the festive opening hours in good time and using as many methods as possible.
- Many regions publish lists of services and contact details for the festive periods – this may include OOH services, pharmacies, etc.
- Find out which hospital clinics may be closed, so you know where to direct patients should they require treatment.

"6 HAPPY STAFF SMILING..."

Christmas is a good time to show your staff how much you value their hard work during the year.

- Consider having a staff Christmas lunch or night out.
- Try to ensure that all staff get some time off, either at Christmas or New Year.
- Be aware that this can be a stressful time of year and offer support to your colleagues if needed.

"5 GOLD RINGS..."

Okay, we don't expect to receive gold rings as presents, but patients sometimes like to give gifts of chocolates, flowers, wine and fruit.

- Ensure the practice has a gift policy and maintains a register of all gifts received.
- Consider sending thank you cards to those patients who brought you presents.
- Don't leave alcohol in consulting rooms as it may give the wrong impression to patients.

"4 SNOW STORMS..."

Practices could find themselves liable if patients injure themselves in the snow and ice.

- Fill up your grit bins and keep snow shovels in the practice.
- Draw up a festive rota for clearing snow. Provide training, supervision and provision of suitable equipment.
- Ensure that you have adequate public liability insurance.
- Keep the temperature of the surgery warm to prevent frozen pipes.

"3 WINTER BUGS..."

Winter brings its own set of illnesses, including novovirus, colds and influenza.

- Encourage eligible patients to have their annual influenza vaccinations.
- Consider providing alcohol handwash stations in the waiting room and patient toilet areas.
- Be vigilant to the possibility of atypical presentations of serious illnesses such as heart attacks.
- Liaise with Public Health nurses, social services and consider offering telephone support vulnerable patients.
- Emotions may run high and if patients need admitting to hospital they may try to stay at home – try to offer the same advice to patients as you would at any other time of year.

"2 EMERGENCY PRESCRIPTIONS..."

It is amazing how many patients leave prescription requests until the last minute.

- Ask patients to request prescriptions in advance.
- Consider printing reminders on the right-hand side of prescriptions, advertising in the local newsletter and on notices, and consider sending text reminders.
- If sending text reminders, ensure you follow the guidance in the Medical Protection factsheet 'Communicating with patients by text.'
- Allocate extra time in the week to deal with extra prescription requests.
- Make sure the practice emergency cupboard is well stocked.

"AND AN OSTRICH IN A CHRISTMAS TREE..."

Don't be an ostrich and bury your head in the sand, or behind the sparkly Christmas tree baubles – be prepared.

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