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Medical Protection

Practice MATTERS

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MEET DR MARY FAVIER PRESIDENT OF THE ICGP

FIND OUT MORE ABOUT THE INITIATIVES SHE IS WORKING ON

Page 4

THIS ISSUE...

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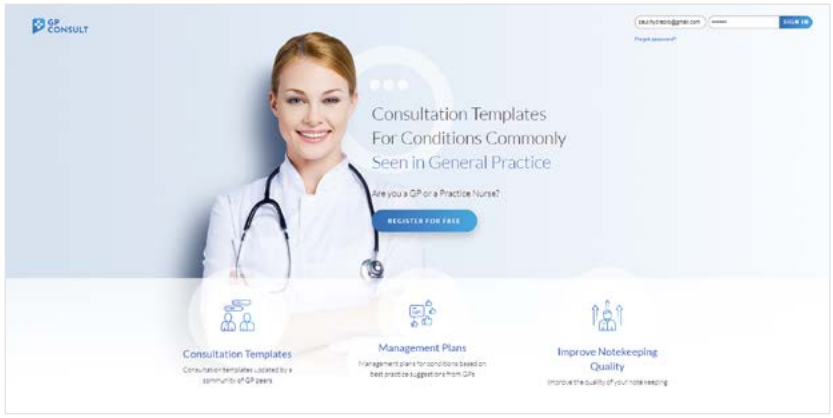
What's INSIDE...



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WELCOME

General practice is a rewarding career and there can be no greater privilege than to be entrusted by patients to provide them with healthcare. There are many challenges in primary care – not least the increase in workload and expectation. However, it is important to remember why you chose the career in the first place and take steps to reduce any risk associated with the extra demand. This edition of *Practice Matters* focuses on ways you can make your practice safer, for both staff and patients.

On pages 5-7, Anna Francis, *Practice Matters*' Content Editor talks to Dr Mary Favier about her position as President of the Irish College of General Practitioners, her priorities for general practice and the initiatives she's working on.

As we are now into flu season, on pages 8-9 Suzanne Creed, Clinical Risk and Education Manager provides some essential tips for infection prevention and control within your practice. On page 18, Suzanne goes on to examine some of the potential pitfalls associated with test result handling and outlines some practical strategies to reduce these risks and ultimately improve the quality of patient care. GPs will be aware that there are new guidelines on the prescribing of valproate for women of child-bearing age. Pages 10-11 address a scenario where the patient has not been seen by her treating specialist recently and discuss ways in which the GP may proceed.

On pages 12-13 Dr Paul Ryan, GP and clinical pharmacist, talks to us about a new risk management tool, GP Consult, that he has developed to enable GPs to share information with one another. It has been welcomed by GPs and trainees alike, as knowledge shared can help to save time, promote learning from peers and ultimately contribute to better patient care. GP Consult is a free resource available to all members of Medical Protection.

You will no doubt be aware that the Patient Safety Bill 2018 proposes to make open disclosure mandatory in certain "serious patient safety incidents". This is an important step in maintaining public and patient trust in healthcare. On pages 14-15, Rebecca Ryan, partner at Mathesons Healthcare Law Group, looks at the instances in which open disclosure will become mandatory and provides some practical advice for clinicians.

Many practice nurses are choosing to expand their roles, taking on more responsibility, developing areas of special interest and managing their own workloads. It is essential that you have appropriate clinical indemnity arrangements in place to protect your practice nurse. You can read more about this on page 16. At Medical Protection we are enthusiastic about helping GP trainees as they embark on their career in general practice. On page 17 we detail what you can expect from your membership, as well as highlighting ways in which we can support your professional development.

I hope you enjoy this edition of *Practice Matters*.

Dr Rachel Birch
Editor-in-Chief and Medicolegal Consultant

MEET DR MARY FAVIER – PRESIDENT OF THE ICGP

Our Content Editor, *Anna Francis*, talks to *Dr Mary Favier* about her position as President of the Irish College of General Practitioners and the initiatives she's working on within general practice

Anna Francis: Hi Mary, can you tell me a bit more about how you became President of the ICGP and what attracted you to the position?

Mary Favier: I've been involved with the college for a very long time in a variety of roles. I started out doing the membership exams and then I actually joined the college as the first Educational Fellow on what was called the Quality in Practice Program, writing educational materials for GPs.

I did that for four years and then I took up various representative roles in the college, including Chair of the Education Committee. I've been a Council representative for many years, and from there it was suggested to me that I run for president. The process involves becoming Vice President; first by election, then becoming President for a year, and after this you're the immediate Past President; so it is actually a three-year appointment.

AF: So now you're in the position of President, what are your aims and objectives for the year ahead?

MF: Firstly, I want to work on strengthening the communication pathways that exist between the central college board and executive, the faculties that are the representative structures beneath that and the members. The college is going through an inevitable process of change. At 30 years old we first had the original pioneers who set up the college and it was very much part of their life. Then we were in a settler phase where people got used to it and sort of took it for granted. And now we have a whole new generation who may only know the college in relation to exam structures, assessments and competency testing. I want to try and encourage them to see the college as part of their lifelong general practice journey, throughout their career, whether that's in terms of education, membership benefits, collegiality or professionalism.

Secondly, a lot of GPs feel the significant impact of Medical Council complaints that come in, even though many of them turn out to be relatively minor – some are even frivolous. But the full weight of the investigation process has to take place, however minor. So, if you look at the fact that there are approximately 3,500 general practitioners in Ireland, with about 27 million consultations a year, there are about 400 general practice complaints. But, of those 400 complaints, only two or three go through to an actual fitness to practise inquiry.

That's a lot of activity for a very small amount of significant concern, and GPs get very upset about this and it can be very stressful. So, we're now working with the Medical Council to look at whether there are better ways this could be managed.

The first principle is that we must protect the patients, and the Medical Council primarily exists to protect their safety. Yet GPs feel that there must be a better way, as many patients aren't satisfied with the way their complaints get resolved, because it's very binary – it's all or nothing. Often, they just want to be heard. So that's a project I've been working on with Dr Rita Doyle, who's the President of the Medical Council and who is actually a former president of the ICGP.

Another thing I want to look at is the issue of planetary health and the impact of climate change on health. What is the role of a general practitioner in trying to address some of these issues: how does climate change affect our work and what is the role of planetary health in the health of our patients?

AF: You've helped set up the Termination of Pregnancy service in general practice and you're a member of the 'southern taskgroup on abortion and reproductive topics' (START) group – can you tell me a bit more about that?

MF: One of the things I've long been active in is the area of reproductive health, working as an advocate for women in changing the law around the repealing of the Eighth Amendment. I've recently been involved with the college, helping to draw up interim clinical guidance so that GPs could be trained for what was a new and entirely novel service, and I've been involved in the START GP group, which helped provide that training.

I've been working with START and the Director of Women's Health in the ICGP to support GP providers who wanted to be ready for the first of January this year, and we're very pleased with how successful it's been.

Following this, we're focussing on the provision of free contraception – we don't actually have a universal coverage contraception service that people are entitled to, so we're working on that. Hopefully this will come to fruition in the next six months – it's just gone out to government-organised public consultation.

AF: You sound like you have quite a lot on your plate – what sort of challenges do you think you might see in the year ahead?

MF: Well I'm currently busy working at my general practice in Cork – I work in an area of high urban deprivation. Our practice is part of the Deep End group, which started in Scotland and is an initiative there, and now here, for groups of GPs who work in areas of high deprivation, both urban and rural, to get together to support each other, but also to look at all the research about what the particular needs and attributes are for that type of practice. We are aware of them in our own practices in terms of lower health literacy, more complex needs, multi-morbidity occurring at a much earlier age and psychosocial stressors that may be more significant.

AF: So what's your favourite thing about working in general practice?

MF: I think the variety – it's the aspect of 'the cradle to the grave' and the fact that you know these people who are your patients and you follow them on their life and health journey, sometimes through their entire lives. I've been in my practice now for over 20 years. I've been a GP for nearly 30 years and that's a privilege. You never know what's going to come through the door on any day and what attitudes, knowledge or skills you will need, and I really like that.

For example, this morning I went through everything from a hospital discharge of a patient who presented with ketoacidosis to an early psychosis presentation; from a snotty-nosed child to the contraceptive needs of a perimenopausal woman.

AF: What do you do to relax and why do you think it's so important to make sure you have a good work/life balance?

MF: I think it's key to have a good work/life balance because you'd never stick it out otherwise. I have two teenage children who have just gone to college, so I had spent a lot of time running around after them. But I also love to garden. Spinning class is my exercise and I will spin until I drop. It's important to leave your 'to do' list in your work inbox and keep the balance. And a big element of it is that you should try and practise what you preach in terms of the life advice we give to patients.

AF: In terms of your role on the MPS Council, what drew you to that and what has it done for you?

MF: That's one of those serendipitous opportunities. I met Tim Hegan, a former GP, when I was working in Australia doing GP locum work many moons ago and he got in touch when he was later working for Medical Protection at a senior level. I hadn't spoken to him for 15 years, maybe longer, and he contacted me saying he had come across my name in a medical article and would I consider applying for the job on the MPS Council. I applied and interviewed and got it – which is extraordinary since I didn't really quite understand what I was getting myself into.

The role was so interesting, and I learned so much – it has really informed my work. I now write medical reports for some of the Medical Protection cases, sometimes for other indemnity organisations and occasionally for plaintiffs. I like that type of work – it's a nice cerebral break from the face-to-face aspect of daily general practice. There are very few bad or incompetent general practitioners and it's usually the classic Swiss cheese effect that Medical Protection talks about, when the little risk holes all line up in a straight line and the bullet of harm goes straight through and hits the patient.

We all have those potential situations and there's very rarely a case that I would look at or examine when I wouldn't think that it could have happened to me. It's provided me with very useful learning points in terms of safety in our practice and significant event auditing, and we now talk about 'near hits' rather than 'near misses'. I now do day release teaching with GP trainees, looking at medical risk management, how medicolegal cases are constructed and run, why certain Medical Council cases occur and how the trainees might protect themselves against complaints and litigation.

For most of us, this centres around good notes – record keeping is everything. The majority of cases that I deal with involve competent GPs whose notes let them down a bit, and you're left with just their word against the plaintiff's. If I could suggest one thing for doctors to always try to improve it would be their records and note keeping.

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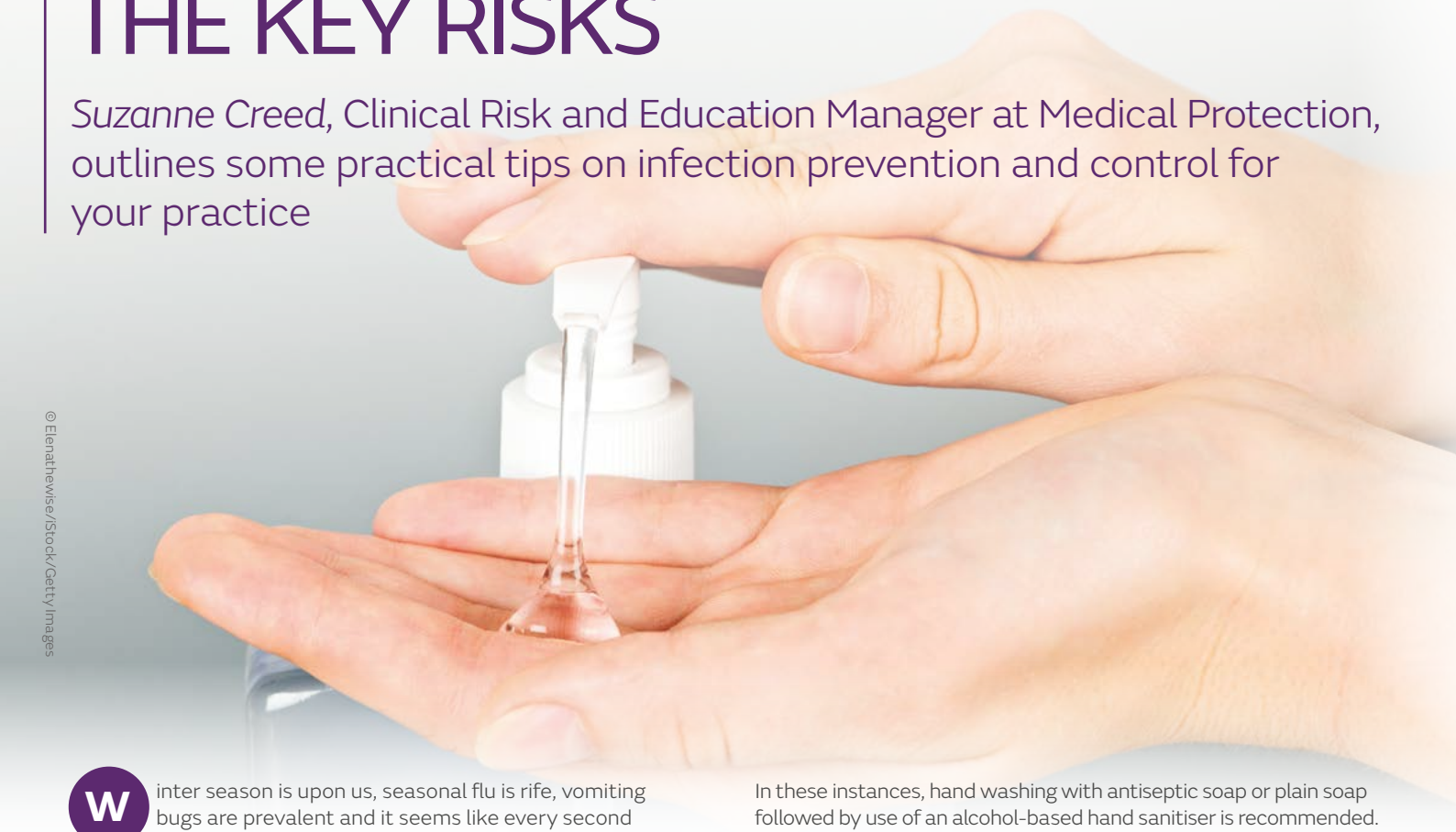
INFECTION PREVENTION AND CONTROL – MITIGATING THE KEY RISKS

Suzanne Creed, Clinical Risk and Education Manager at Medical Protection, outlines some practical tips on infection prevention and control for your practice



Winter season is upon us, seasonal flu is rife, vomiting bugs are prevalent and it seems like every second patient is complaining of a cough and cold – does this sound familiar? Perhaps it's a good time to think about infection prevention and control in your practice?

This is an essential element of care and one that has often been undervalued in recent years. All staff, clinical and non-clinical, have a responsibility to help reduce the prevalence of healthcare-associated infections. Infection prevention and control is not just about keeping your patients safe, but also keeping you and your practice staff safe. So let's consider some of the key risks and how to mitigate them in your practice.

HAND HYGIENE

According to the Health Information and Quality Authority (HIQA), hand hygiene is recognised as the most important preventative measure in transmission of healthcare associated infections.[1] Effective hand hygiene prevents the transmission of micro-organisms to you and others.

Recommendations

All healthcare staff should be taught how to correctly clean their hands with alcohol-based hand sanitiser and soap and water. Alcohol-based hand sanitiser is the recommended product in all patient care situations except:

- After contact with a patient with known or suspected diarrhoea, eg clostridium difficile or norovirus.
- Where hands are visibly soiled.
- When there is direct hand contact with bodily fluids, ie if gloves were not worn.
- If the patient is experiencing vomiting or diarrhoea.

In these instances, hand washing with antiseptic soap or plain soap followed by use of an alcohol-based hand sanitiser is recommended. Ideally you should make available:

- liquid soap dispensers
- appropriately-placed sanitiser
- paper towels
- elbow-operated mixer taps
- a designated hand washbasin, separate from the one used for equipment, etc.

PROTECTING YOUR STAFF

As employers, GPs should introduce reasonable measures to minimise the risk of employees acquiring or spreading infection. GPs, practice nurses, administrative and cleaning staff may all be exposed to communicable diseases or blood/bodily fluid exposure and therefore should be vaccinated as appropriate. Staff vaccination reduces the risk of contracting various diseases, reduces onward transmission of disease to patients and avoids sick days due to ill health. The *Infection Prevention and Control Guidelines for Primary Care* states: "Decisions about vaccinations recommended should be based on the duties of the individual rather than on job title alone."[2]

Recommendations

All staff members should be offered vaccination against influenza on an annual basis each autumn. Healthcare workers who are at occupational risk of exposure to blood or bodily fluids or who perform exposure-prone duties should be immunised against hepatitis B. This includes your practice cleaner. In line with the *Infection Prevention and Control Guidelines for Primary Care*, staff should also be screened and offered vaccinations against:

- BCG (Bacillus Calmette Guerin)
- Varicella
- MMR (measles, mumps, rubella).[2]

SPECIMEN HANDLING

How often do reception staff at your practice handle specimens? Do your patients drop in samples in inappropriate containers and pass them directly to your reception staff? The outside of these containers could be contaminated, resulting in a risk to your staff.

Recommendations

Reception staff should not touch patient specimens and samples, and inappropriate containers should not be accepted. Clinical staff should issue the patient with a labelled specimen container and appropriate pathology bag when requesting a sample, thus ensuring samples are transported safely and removing the need to decant samples. A drop-box could be provided at the reception desk for patients to leave their samples in, which could then be passed directly to the clinical staff.

DEALING WITH SPILLAGES

Who deals with spillages in your surgery? Have they been appropriately trained? As with any GP practice, unexpected spills of blood, urine or vomit are not uncommon. Blood and body fluid spills should be dealt with swiftly and effectively to minimise risks to staff and patients. All staff should know who is responsible for spillage management in their work area. They should be appropriately trained and have the necessary equipment to manage the spill.

Recommendations

Practice staff should be provided with appropriate training. *The Infection Prevention and Control Guidelines for Primary Care* provides guidance on the management of different types of spillages, ie blood, urine and vomit.[2]

Consider providing a 'grab bucket' containing all the relevant equipment. This should be readily available to deal with any spillage of body fluids. The kit should be kept in a designated place and you may need more than one.

The kit should comprise of a:

- 'nappy' type bucket with a lid
- non-sterile vinyl gloves and latex/nitrile gloves for contact with blood
- disposable plastic apron
- disposable face protection
- disposable paper towels
- disposable cloths
- clinical waste bag
- small container of general purpose detergent
- sodium dichloroisocyanurate compound NaDCC (eg Presept®, Sanichlor®, Haz-Tabs®) or hypochlorite solution (eg household bleach or Milton®). These chemicals should be kept in a lockable cupboard
- absorbent powder, eg Vernagel® to soak up the liquid content of the spillage
- floor warning sign.

The kit should be immediately replenished after use.

CLEANING AND DECONTAMINATION OF REUSABLE INSTRUMENTS

Many practices find it challenging to comply with current guidelines for decontamination of reusable instruments – in particular, having separate clean and dirty areas for decontaminating equipment that is not a clinical room or used for any other purpose, having separate sinks for washing and rinsing instruments and a thermal washer for cleaning instruments, to name just a few.

Failure to comply with current guidelines as outlined by HIQA,[1] Infection Prevention and Control Guidelines for Primary Care,[2], HPRA[3] and the HSE Code of Practice for Decontamination of RIMD[4] would make a claim difficult to defend should a patient suffer an adverse event.

Recommendations

Consider using single-use disposable equipment. This will remove the need for decontamination procedures. If your practice uses reusable medical devices you need to ensure that your decontamination processes are safe and robust, and fully comply with current standards and guidelines.

CLEANING OF THE PRACTICE PREMISES

Having clean premises will not just have a positive impact on a patient's experience but will also reduce micro-organisms in the environment. It is important to have routine environmental cleaning to minimise the number of micro-organisms and to ensure cross contamination is greatly reduced.

Recommendations

Develop a detailed cleaning schedule for your practice. This should provide details about how the environment and equipment, eg chairs and examination couches, are to be cleaned and should detail the frequency and method of cleaning. Floor mops should be regularly washed and changed periodically. Mops and buckets should be colour coded and different mops should be used to clean clinical and public areas. Mops should be hung to dry and not left wet in buckets. Cleanliness of the premises should be regularly monitored and any shortcomings addressed with your cleaner or cleaning company.

TRAINING AND GUIDELINES FOR YOUR PRACTICE

All staff should receive training in infection prevention and control at induction and have regular updates. Key topics should include: hand hygiene, management of sharps and clinical waste, and management of spillages, amongst others.

It may be helpful to consider appointing a designated lead within the practice who will take charge for infection control issues. You should discuss and develop a robust infection control policy and ensure all staff are conversant in its contents. It is essential to ensure the policy is regularly reviewed and updated.

Medical Protection has developed an interactive Infection Control Risk Assessment and Workshop to give general practice teams a clear understanding of the importance of infection control, providing you with the necessary skills to manage and reduce infection in your practice.

Infection prevention and control is a fundamental part of a high quality general practice service. It will ensure the safety and wellbeing of patients, staff and visitors to your practice. Achieving and maintaining the highest hygiene standards is everyone's responsibility.

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GP DILEMMA: PRESCRIBING VALPROATE

In 2018, new guidelines were issued on the prescribing of valproate, introducing strict criteria for female patients who are either pregnant or of child-bearing age. As a GP, what should you do when a patient already taking a valproate medicine attends for another prescription without meeting these criteria?

On 21 March 2018, the Coordination Group for Mutual Recognition and Decentralised Procedures – Human (CMDh) authorised new measures to avoid babies being exposed to valproate medicines in the womb, due to the high risk of malformations and developmental problems.[1]

While medicines containing valproate have been approved nationally and within the EU to treat conditions such as epilepsy and bipolar disorder – and in some countries, migraines – these new measures include a ban on the use of valproate during pregnancy.

For women or girls who are not pregnant, but are of child-bearing age, valproate must not be prescribed unless all the Valproate Pregnancy Prevention Programme conditions – outlined by the Health Products Regulatory Agency (HPRA)[2] – are met.

The strict rules, set out by the Valproate Pregnancy Prevention Programme, include ensuring that female patients taking valproate medicines:

- have been told and understand the risks of use in pregnancy and have signed a Risk Acknowledgement Form
- are on highly effective contraception if necessary
- see their specialist at least every year.

But what happens if a patient already taking a valproate medicine comes for another prescription and doesn't meet one of the above criteria?

MAKING A JUDGMENT CALL

If a patient's medication is stopped abruptly, it can present a health risk. But if a doctor were to prescribe outside the Pregnancy Prevention Programme it can present a medicolegal risk, and if the patient becomes pregnant, a potential risk to an unborn child.

There is no explicit guidance on how GPs should proceed in the event that an Annual Risk Acknowledgement Form has not been completed, so you should exercise your own clinical judgment and consider available professional guidance, such as the Medical Council's ethical guide.[3]

The Medical Council advises doctors to ensure that prescriptions are "safe, evidence-based and in the patient's best interests." Doctors should "weigh up the potential benefits with the risks of adverse effects and interactions when deciding what to prescribe."

Where an annual review with a specialist has not been carried out in time, in accordance with the Pregnancy Prevention Programme, a GP would need to consider whether it is justifiable to continue to prescribe valproate medication, for example, if the risk to health of stopping the medication abruptly is deemed to be greater than the risk of temporarily continuing the medication. Once the decision has been made it should be documented in the patient's medical record, along with the rationale for it.

However, any such prescription should function only as a stopgap between the last annual review and the next available opportunity for the annual specialist review to be conducted. The prescription should be approached with due caution, both for the safety of the patient primarily, and to ensure that you are in a position to explain and justify a decision to continue prescribing valproate medicines.

The benefits and risks of the medication should be carefully reconsidered at regular treatment reviews. It may be a decade or more before harm emerges, and accurate, detailed and contemporaneous medical records are crucial. The HPRA has a comprehensive patient information booklet[4] that should be shared with the patient, with this clearly documented in the medical record.

A thorough discussion should be had with the patient, where you detail the risks as noted in the Risk Acknowledgement Form.[5] You should explain that while a specialist would normally complete the form, in the current circumstances it is good practice for you – as the prescribing GP – to be assured of the patient's awareness of the associated risks before any repeat prescription.

This discussion should be accurately documented in the patient's notes. In this way, the purpose of the Annual Risk Acknowledgement Form may still be fulfilled in lieu of the form being completed in due course.

It is also advisable for you to enquire as to why the specialist annual review has not taken place. You should liaise with the patient and secondary care to ensure this required review is conducted as a matter of urgency where the review date has passed.

RAISING CONCERNS

If you are concerned that an issue has been caused by secondary care not reviewing the patient when required, this should be raised via the appropriate channels – in the first instance, with the secondary care provider itself. Any efforts made to liaise with secondary care and local services should be well documented in the patient's notes.

Alternatively, if the patient concerned has not attended their annual review, this should be urgently addressed directly with the patient, stressing the importance of attendance to their continued treatment and care.

Medical Protection has a three-hour *Medication Errors and Safer Prescribing* workshop, which has been developed for, and is delivered by, GPs and is free as a benefit of membership.

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REINVENTING RECORD KEEPING

We all know the importance of keeping good records, and now GP Consult makes it easier than ever for doctors to make clear, timely patient notes. *Dr Paul Ryan*, GP and clinical pharmacist, talks to us about his experience with record keeping and how this new resource can help

© Paul Ryan

Good medical records are essential for the continuity of care of patients and play a vital role in responding to a complaint or defending a clinical negligence claim. If a complete and accurate medical record is documented, it can make all the difference. Most medicolegal cases focus at some level on the availability of medical records and their contents, so they can make the difference between whether a case is defendable or not.

I've always been very aware of how important it is for me to take the time to sit down and make a note of every discussion I've had with a patient, every examination I've carried out and any action plan that's been put in place. It takes time and can create a lot of work but ultimately it's the key to recording everything that happens when I see a patient.

Prescribing guidelines used in Ireland tend to be mainly based on international, as opposed to Irish, guidelines. This is a challenge because not all the medications used in Ireland are on these guidelines and some medications mentioned in the guidelines aren't available for patients in Ireland.

There are also different reimbursement schemes in Ireland, such as the General Medical Services (GMS) scheme, the Drugs Payment Scheme (DPS) and the hardship scheme. So, for example, if you prescribe antihypertensives as recommended in the UK guidelines, these may not be available under one of these schemes, so may not be affordable for the patient. There are also medications on these prescribing guidelines that are unlicensed in Ireland, and hence difficult to source.

This makes it time consuming and complicated for GPs. Pharmacists will need to go back and forth with GPs, discussing which drugs are available, which are not and what alternatives could be used. This can be especially hard for new GPs and trainees who are relying on the guidelines.

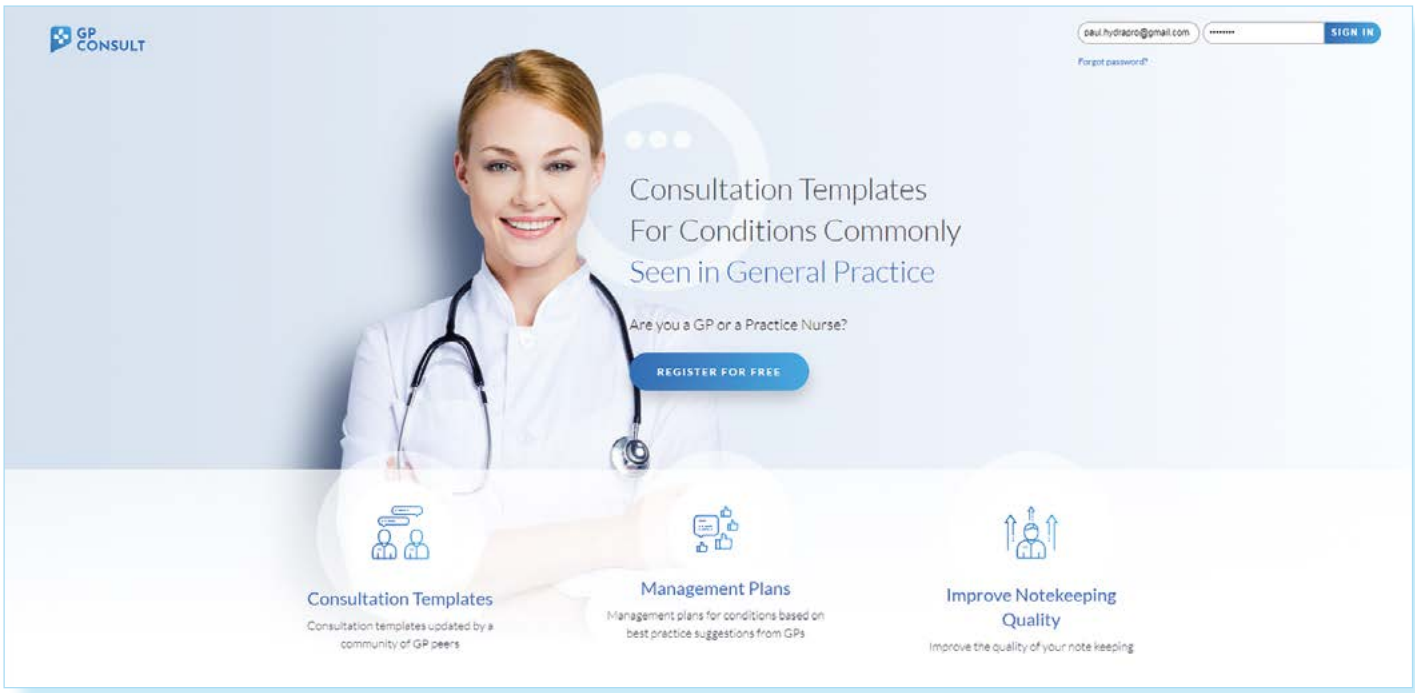
When I started working as a pharmacist 15 years ago, I was asked by GPs and GP registrars to give them some tips and tricks to make prescribing easier and safer in Irish general practice.

A lot of the notes I had developed were short summaries of the UK guidelines that I had made relevant to Ireland. This collection of notes and documents has slowly grown to incorporate history and examination templates, as suggested by GP peers – including relevant red flags to look out for.

This led me to create GP Consult – a platform dedicated to providing GPs with the relevant resources they could use to make their working lives easier and their time more efficient. It works on the idea that GPs across the country can share information on history and examination templates, as well as management plans for everyday conditions seen in general practice.

> The templates and treatment plans can save them up to three minutes per consultation

Using GP Consult



Once logged in, users can search for advice through a range of categories, such as respiratory, ENT and cardiology, and find tips and templates to use for a variety of symptoms and conditions. Once they've run through the relevant questions to ask their patient and looked at the appropriate templates, they can record all answers and discussions in their notes to ensure they have accurate and concise records.

It's easy for users to add their own tips and advice – they simply find a category they want to add to and enter a comment in the box at the bottom. The GP Consult team of moderators then just need to check that it's evidence-based and relevant, and they then approve it to go live.

Feedback from GPs who use the site has been overwhelmingly positive, as the templates and treatment plans can save them up to three minutes per consultation.

What I really like about GP Consult is the goodwill and willingness from GPs to share information between one another. GPs or GP trainees who register will be joining a community of GPs who want to make the working lives of their peers easier and safer, by sharing knowledge that they have accumulated from their own experience in practice.

This risk management tool is there to guide GPs, save them time and help them learn from their peers. I hope to see it grow and become a resource that can not only help GPs but also improve patient care throughout Ireland.

GP Consult is a free resource available to all members of Medical Protection.

Simply visit **gpconsult.ie** and sign up.

> GP Consult is high yield medicine. With over 200 templates it is perfect for the GP trainee on the steep learning curve or for the experienced GP who wants to enhance specific areas of interest. GP Consult gives me comfort and reassurance that I won't miss any red flag symptom

Domhnall Heron, GP registrar, Sligo training scheme

MANDATORY OPEN DISCLOSURE

Rebecca Ryan, partner at Matheson's Healthcare Law Group, looks at the instances in which open disclosure will become mandatory and provides some practical advice for clinicians

Open disclosure is an open and consistent approach to communicating with patients and their families when things go wrong in healthcare. This includes expressing regret for what has happened, keeping the patient informed, providing feedback on investigations and taking steps to prevent a recurrence of the adverse event. Open disclosure is important for building patient and public trust in the health system.[1]

As you may have read in the previous issue of *Practice Matters* earlier this year, there is currently legal protection in place for apologies to patients issued through the open disclosure procedure.[2] Until September 2018, an apology given to a patient could potentially be used as evidence in legal proceedings or referred to in a complaint to the Medical Council.

While this procedure is currently voluntary, the Patient Safety Bill 2018 proposes to make open disclosure mandatory in certain 'serious patient safety incidents'. As the previous article sought to make readers aware of the relatively new legal protection for apologies, this article aims to serve as a follow up, detailing the instances in which open disclosure will be mandatory and providing practical advice for clinicians.

While there is currently no certain timeline for the implementation of the Patient Safety Bill, clinicians need to prepare appropriately well in advance of the passage of the Bill into law.

TIMELINE AND UPDATES ON LEGISLATION

The status quo will remain for the foreseeable future despite criticism following the Scally Report.[3] The legislation, intended to implement recommended changes, still only exists in the form of a general scheme published in July 2018 by the Department of Health and Social Care.

Earlier this year, the Minister for Health, Simon Harris, indicated an intention to commence the passing of mandatory open disclosure into law by the end of 2019. While it remains to be seen whether the legislation to effect this change to the open disclosure procedure will be implemented this year, clinicians can be expected to abide by existing guidelines in the short term. While it is anticipated to provide clarity on the provision of apologies and on open disclosure this year, the 9th edition of the Medical Council's *Ethical Guide and Code of Conduct* remains unpublished as yet.

THE LAW AS IT STANDS

The law surrounding open disclosure is currently governed by the Civil Liability (Amendment) Act 2017. The Act provides the legal framework to support voluntary open disclosure; it applies to all patient safety incidents including near misses and no-harm events. It provides for an open and consistent approach to communicating with patients and their families, allowing an apology, as appropriate, when things go wrong in healthcare. The approach is intended to create a positive voluntary climate for open disclosure.

The Act defines a patient safety incident as one of the following:

- an incident that resulted in an unintended or unanticipated injury, or harm, to a patient during the course of provision of a health service
- an incident that has not resulted in actual injury or harm but where a clinician has reasonable grounds to believe a patient was placed at risk of unintended injury or harm
- the prevention by timely intervention or chance of an unanticipated injury or harm which the clinician has reasonable grounds to believe that, in the absence of the prevention, could have resulted in injury or harm to a patient.[4]

THE PATIENT SAFETY BILL AND MANDATORY OPEN DISCLOSURES

The government approved the general scheme of the Patient Safety Bill on 5 July 2018. This Bill provides for mandatory open disclosure, mandatory external notification of patient safety incidents, clinical audit guidance and the extension of the remit of HIQA to private hospitals.

While the current form of the Bill may only be in a general scheme, we can discern critical definitions and procedures from Head 5 of the scheme (mandatory open disclosure) as it is proposed by the Department of Health and Social Care.

Mandatory open disclosures are intended to be required when a serious patient safety incident arises. These are defined as:

- the death of a patient
- the permanent lessening of functions, eg organ/brain damage or the removal of the wrong limb (referred to as 'severe harm')
- non-severe harm that results in the increase in a patient's treatment
- change in the structure of the body
- shortened life expectancy
- impairment of sensory, motor or intellectual functions for a period of at least 28 continuous days
- the experience of physical or psychological pain for a period of at least 28 continuous days
- that a person requires treatment to prevent death or injury that if left untreated, would lead to severe harm or non-severe harm.[5]

It is important to note that this list may not be exhaustive in future and the Bill, as proposed, gives the Minister for Health the discretion to prescribe more definitions in the future.

In terms of the new proposed reporting framework, Head 9 of the scheme (Notification of reportable incidents) establishes a timeline for the reporting of serious incidents. A person will be required to report the incident to the HSE as soon as possible, and within no more than seven days of the incident occurring. The HSE must then contact the State Claims Agency and the relevant regulators (Medical Council or Dental Council) within the same timeframe, commencing when the relevant health service provider received notification. The regulators are intended to be HIQA, the Chief Inspector of Social Services in the case of residential services, and the Mental Health Commission in the case of mental health services. Where a notification is received under this Head, the regulator will be in a position to take action as it considers appropriate under its own legislation.[6]

PRACTICAL IMPLICATIONS FOR CLINICIANS

As the Patient Safety Bill proposes to keep the current framework surrounding the open disclosure procedure, clinicians do not need to worry about an increased workload on this front. However, it will be important to note the definitions of serious incidents within the new regulations as it will be these, and only these, that are considered mandatory to report and disclose. When the changes are implemented, it will be important for all relevant health service providers to have systems in place to process the reporting of serious patient safety incidents within the required timeframe. This is absolutely vital, as failure to comply with the legislation will carry severe penalties. A less serious violation of the new regulation could result in a fine of up to €5,000, a prison sentence not exceeding three months, or both. A more serious violation could result in the health service provider being fined up to €7,000, a prison sentence not exceeding six months, or both.

For these reasons it is essential for clinicians to put the appropriate systems, policies and checklists in place in preparation for the mandatory open disclosure procedure. The 9th Edition of the Medical Council's *Ethical Guide and Code of Conduct* is being published this year and should provide greater clarity on the mandatory open disclosure procedure.

REFERENCES

1. Health.gov.ie. Department of Health. [online] Available at: health.gov.ie/ 2019.
2. S.I. 10 No. 237/2018 – Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018.
3. Scally, G. 2018. Scoping Inquiry into the CervicalCheck Screening Programme. Final report. Dublin, September 2018.
4. Section 8, Civil Liability (Amendment) Act 2018.
5. Head 5, Patient Safety Bill 2018.
6. 6 Head 9, Patient Safety Bill 2018.

PRACTICE NURSE INDEMNITY – Is your nurse adequately protected?

During a busy Friday morning clinic, Mrs S, 26 years old, came to see Nurse M with her son for his six month vaccinations. After the injections had been given, Mrs S mentioned to the nurse that she had been having vague tummy pains and thought she may have a urinary tract infection (UTI), as she had suffered from them in the past.

Nurse M asked her if she wanted to see the GP, but Mrs S declined. Nurse M said that it was perhaps a UTI and agreed to do a urinalysis and send a sample to the laboratory.

The urinalysis showed a trace of protein and +1 of blood. Nurse M agreed she would send the sample to the lab for culture and sensitivity. Nurse M advised Mrs S to take plenty of fluids and pain relief and to return to see the GP if she was no better.

Nurse M made the following entry in the clinical notes:

"In with son for routine 6 month vaccinations.

Patient mentioned lower abdominal discomfort, nothing specific, felt it could be UTI.

Urinalysis – trace blood, +1 protein.

Sample sent to lab.

Advised to phone for results."

Later that night, Mrs S developed severe abdominal pain and collapsed; she was seen by a GP from the OOH service and was admitted by ambulance to the Emergency Department. Mrs S died shortly after arriving in hospital. A postmortem examination confirmed the cause of death as a haemorrhage from a ruptured right tubal pregnancy.

Her death was reported to the coroner by the Emergency Department staff and the coroner instigated an investigation into the circumstances surrounding the death. Nurse M was called to give evidence at the coroner's inquest. The coroner returned a verdict of natural causes. The family pursued a claim of clinical negligence against the nurse.

MEDICAL INDEMNITY FOR PRACTICE NURSES

The Nursing and Midwifery Board of Ireland (NMBI) Scope of Nursing and Midwifery Practice framework outlines the professional responsibilities of nurses and midwives working in Ireland.[1]

It states: "Nurses and midwives are accountable both legally and professionally for their practice, that is, for the decisions they make and the consequences of those decisions." It also states that: "You are responsible for ensuring you have, or need to get, professional indemnity insurance".

For this reason, all practice nurses should ensure that they have their own appropriate indemnity.

DOES MY GP INDEMNITY EXTEND TO THE VICARIOUS LIABILITY OF MY PRACTICE NURSE?

No. 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 with Medical Protection do not include vicarious liability protection for the nurse.

MEDICAL PROTECTION INDEMNITY FOR PRACTICE NURSES – WHO CAN APPLY?

Practice nurses and nurse practitioners employed by a member of Medical Protection (or their practice) can apply for membership in their own right. The annual subscription is €399 for practice nurses or €689 for nurse practitioners. These rates are correct as of 1 May 2019.[2]

The benefits of Medical Protection membership are provided on an occurrence basis. This means that members can apply for assistance with complaints and claims arising from incidents that occur during their membership – even if it is brought years after they have left Medical Protection or ceased to practise for any reason. In this example, if Nurse M had been a member of Medical Protection at the time of her consultation with Mrs S, she would have been able to request assistance with the inquest, where we would have provided legal representation or assisted with her report. Similarly she would have been indemnified for the subsequent claim.

OUT OF HOURS

Nurses working in urgent or out of hours care should contact Member Services on 1800 509 441 to join Medical Protection.

MIDWIVES

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.

Membership does not extend to practice nurses undertaking the assessment of foetal growth, presentation, viability or scanning.

CONCLUSION

As the role of the practice nurse expands, so too does the risk of an adverse event occurring. Many nurses work in isolation, managing their own clinical workload – this in itself may present additional risks to safe and effective practice. Medical Protection has seen a steady rise in the number of claims relating to general practice, some of which involve nurses. It is therefore essential that nurses have appropriate clinical indemnity arrangements in place.

REFERENCES

1. Nmbi.ie. 2019. NMBI – NMBI Scope of Practice. [online] Available at: nmbi.ie/Standards-Guidance/Scope-of-Practice
2. 2 Medicalprotection.org. 2019. MPS membership for practice nurses in Ireland. [online] Available at: medicalprotection.org/ireland/join/practice-nurse-membership

INVESTING IN GP training

Medical Protection is committed to providing professional support, advice and protection to GP trainees. This helps you to start your career in general practice with confidence, knowing that we can be here to help you when you need us and we aim to be an active partner in your career.

Each year we offer a three-hour educational workshop to all GP trainees across the 14 GP training schemes in Ireland. These workshops are all delivered by expert clinicians who have worked in Irish general practice and have a wide range of experience and training in education and risk management.

The topics covered are designed to enhance your skills in communication and risk management – they target the areas that are most likely to expose you to complaints and claims.

This year we covered the following topics:

- Infection control in general practice.
- Learning from events in general practice.
- Managing conflict and aggression in general practice.
- Safer management of test results.
- Medication errors and safer prescribing in primary care.
- Your repeat prescribing journey.
- Medical records in general practice.
- Consent in general practice.

"

As the medicolegal environment grows ever more hostile, the need for risk management becomes more compelling.

Educational sessions provided by Medical Protection help address some of the challenges of clinical practice by underlining the importance of good communication skills, and the need for implementation of risk management strategies to enhance safe practice. Incorporation of these sessions into the day-release programme of GP training helps to increase awareness of best practice in these areas and re-enforce similar messages already delivered from other sources.

As anyone who has attended an educational session run by Medical Protection will know, the material presented at these sessions is well researched, relevant, compelling and informative. Practical advice for dealing with scenarios presented is clear and elaborates on specific skills to enable more effective and safer management.

A culture of patient safety is paramount in medical care. A resilient workforce is equally essential to deliver on this aspiration. Educational sessions delivered by Medical Protection help address this dual challenge.

Dr Sheila Rochford MB, BSc (hons), DCh, DObst, MICGP, MMedEd, FAcadMEd, FRCGP
Assistant Programme Director
Cork GP Training Programme for General Practice

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I am fortunate to have attended two Medical Protection workshops during my training as a fourth year GP registrar. One on repeat prescribing in general practice and one on the management of test results.

The workshops were invaluable from both an educational and staff safety perspective. GP Registrars in attendance took their learnings back to their own practices and implemented a range of positive changes to the benefit of both patients and staff.

The depth of knowledge and delivery of content was of an exceptionally high standard. The workshop was enjoyable and informative and catered for the needs of all practice members, both clinical and non-clinical.

Feedback from staff who attended the workshop was overwhelmingly positive and the practice has arranged to have additional Medical Protection workshops in the future at the request of the practice staff.

The continued educational support provided by Medical Protection has proven invaluable. We look forward to continuing to benefit from the educational opportunities that our Medical Protection membership gives us access to.

Dr Maitiu O Tuathail
GP at Safetynet Primary

"

I had the pleasure of attending a Medical Protection workshop in my final year of GP training. This workshop dealt with practical everyday difficulties encountered in GP practice. The vast experience of the Medical Protection team became apparent as the pitfalls in repeat prescribing were outlined.

This was an interactive session, allowing us all to evaluate our current practice with a firm plan of a repeat prescribing policy on leaving.

A second topic of managing test results was chosen by our cohort. Medical Protection experience was combined with our own everyday situations in order to personalise the learning and improve our current practice.

Through its interactive nature with accompanying information, the workshop is a must for any GP trainee!

Dr Siobhan Coyle, GP Trainee

THE RESULTS ARE IN

Managing test results in general practice is complex. It involves every member of the practice team as well as relying on outside providers. It is vulnerable to human error and there is significant potential for mistakes to occur. *Suzanne Creed*, clinical risk and education manager at Medical Protection, examines some of the key risks in the handling of test results

When was the last time a test result was lost or not conveyed to a patient? Can you be sure that there are no reports in the system that you have not seen or acted upon?

By developing and implementing robust risk management policies and procedures, practices can reduce the risks and thereby prevent avoidable harm to patients.

Medical Protection has been undertaking clinical risk self-assessments (CRSAs) in general practice across the UK and Ireland since 2000. A CRSA is a unique, systematic approach used to identify potential risks within a practice and develop practical solutions to mitigate these risks; ultimately improving the quality of patient care and reducing the practice's exposure to unnecessary risk.

In this article we will look at some of the key risks identified as part of the CRSA programme in Ireland, and outline some strategies to mitigate those risks.

KEY RISKS

No record of tests requested

One of the challenges for practices is ensuring that all samples sent off to the laboratory are returned as results. All clinicians when requesting and taking blood samples should clearly document what has been requested and what has been actually taken in the patient's clinical file. This will allow for any outstanding results to be clearly identified. Simply entering "for routine bloods" is not good clinical practice. It is the GP's responsibility to check the results once they come in and act on them. It is a good idea to regularly review your practice's system, perhaps undertaking an audit of 'ins and outs' of patient samples, to ensure that all test results are returned to the practice.

Clinical review of results

The requesting clinician should review and electronically sign each result in a timely fashion – ideally the same day or next working day. Practices should develop a robust 'buddy system' to manage results when a clinician is absent or on leave. All test results, both normal and abnormal, should be reviewed by a clinician. Although it is usually abnormal results that require action, sometimes normal results may also require actioning – for example, a normal haemoglobin that is falling, or a normal PSA that is rising.

Not informing patients of abnormal results

Responsibility for actioning test results lies with the practice – do not assume that the patient will contact the practice to find out if any action is necessary. It is good practice to have a system for ensuring that the desired action is carried out, eg a follow-up test, investigation or review, by contacting the patient.

The practice should make every effort to contact the patient and record these attempts. Do not file a result unless it is marked as having been actioned. When a patient has contacted the practice for a result, this should also be noted in their record. The time of referral or arranging investigations is an ideal time to confirm patient details, particularly their mobile phone number. This may save some time later when trying to contact the patient with results.

No tracker system to follow up the patient

Do you have a reliable method of checking that the patient has attended their follow up appointment? Failure to adequately follow up with a patient may lead to the delay in diagnosis of a clinically significant condition. Practices should consider having a system for the effective tracking of patients who, the GP feels, require monitoring or follow up.

TOP TIPS

1. Document all tests requested and taken. Confirm all requested tests have returned.
2. All results should be checked by a GP (not the practice nurse).
3. Lab phone calls about abnormal results should be taken by a GP, not the admin team.
4. Responsibility for managing results lies with the requesting GP – do not rely on the patient to phone you.
5. Make reasonable and appropriate effort to inform the patient of abnormal results, and document your efforts.
6. Review all results in a timely fashion; have a written 'GP Buddy' system to cover part time GPs or those on annual leave.

CONCLUSION

Managing risk around test results in general practice is everyone's responsibility. It should become part of everyday activities within the practice and involve both clinical and administrative staff. The whole practice has a part to play in recognising potential risks and mitigating them. Looking closely at existing systems will always bring into view new ways of working and, most importantly, improving patient safety.

CONTACTS

YOU CAN CONTACT MEDICAL PROTECTION FOR ASSISTANCE

medicalprotection.org

Medicolegal advice

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Membership enquiries

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Calls to Membership Services may be recorded for monitoring and training purposes

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