Pharmacy fraud
HANDLING SUSPECTED FRAUD

Inside this issue:
Delegating to healthcare assistants
Latest NICE guidance
Record-keeping checklist
WHERE THE RISKS LIE

MPS General Practice Conference 2012

London | Thursday 14 June | The King’s Fund
Liverpool | Thursday 21 June | Crowne Plaza Hotel
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MPS’s 2012 annual general practice conference will explore where the real risks lie in primary care and take an in-depth view of some specific areas of risk.

Delegates will experience a combination of plenary sessions, Q&A panels and streamed workshops exploring different aspects of medicolegal risk and ethical challenges arising from clinical practice in primary care.

Topics covered include:

- Regulation and redress
- The changing sources of risks – commissioning, continuity of care and vicarious liability
- Claims trends – The MPS experience
- Confidentiality and information sharing
- Challenging patient interactions – Boundaries and breaking bad news
- Human factors and systems errors
- Workshops on: Medicolegal Hot Topics, Reducing an Escalating Complaint, and Employment Law in Practice.

For more information and to register visit: www.mps.org.uk/gp

MPS1397.02/12
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RISK ALERT

Tips to safeguard your practice

MPS data has revealed that the top risk for general practice in 2011 was communication. More than 150 Clinical Risk Self Assessments (CRSAs) of general practices were carried out – resulting in 99.4% identifying communication as a risk.

Confidentiality has traditionally been the highest risk in general practice, but last year communication overtook confidentiality. Healthcare is never without risk and this analysis shows that this does not just relate to clinical issues, but concerns administration, training, policies and procedures and communication.

Most practices have embraced electronic communication, which offers greater convenience and flexibility – but it does bring new problems. The provision of an email address or mobile number does not mean that a patient has consented for their personal information to be communicated in this way.

MPS CRSAs are a proven method of identifying and managing risk. CRSAs encompass a one-day assessment visit where an MPS Risk Assessment Facilitator works with the practice team to identify risks and brainstorm solutions. For further information please visit www.mps.org.uk/crsa.

Welcome

Dr Richard Stacey – Editor-in-chief
MPS Medicolegal Adviser

This issue explores roles and responsibilities in primary care. Repeat prescribing is a major factor in the daily workload of GPs and practice staff, and is also a significant part of the workload for community pharmacists. Our leading feature looks at how to deal with a community pharmacist who is suspected of abusing the repeat prescribing service. Repeat prescribing is fraught with risk; GPs and pharmacists should have written protocols for their respective repeat prescribing responsibilities (and in the case of pharmacists, for dispensing too).

Another risky area where the roles are less defined is that of healthcare assistants (HCAs). Described as the “unsung heroes” of the health service, HCAs do represent a valuable cog in the primary care machine. However, over the years their role has expanded with little consistency in terms of development; as such there is no definitive list of the tasks that an HCA can undertake.

Our feature explores what tasks should be delegated to HCAs. MPS advice is whatever task is delegated to an HCA, the individual responsible for delegating that task, must ensure that they are trained and have the necessary knowledge, skills and competence to undertake the tasks delegated to them.

A foundation stone of safety for a GP is having clear, accurate and legible records. Louise Morgan provides a clinical entries checklist, which if followed will protect against complaints and claims.

I hope you enjoy the issue.

Richard Stacey
GMC bans doctors from signing contracts containing ‘gagging’ clauses

The GMC has published new guidance advising doctors against signing contracts containing ‘gagging’ clauses that would hinder concerns being raised about patient safety.

Raising and Acting on Concerns About Patient Safety points out that all doctors have a duty to act when they believe patients are at risk, or that patients’ care or dignity is being compromised.

The guidance further advises doctors on when they should raise concerns and how to approach their regulator.

MPS director of policy and communications, Dr Stephanie Bown, said: “The guidance very clearly sets out doctors’ responsibilities regarding raising and acting on concerns about patient safety, and should leave them with no doubt about their duties and the expectations of them as professionals.

“We receive calls from members who have seen things that cause them concern, and who are seeking clarification about what to do. Unfortunately, many express fear about the potential consequences of ‘rocking the boat’ and that they might be penalised for speaking up.”

GMC chief executive Niall Dickson described the clauses as totally unacceptable. “Doctors who sign such contracts are breaking their professional obligations and are putting patients, and their careers, at risk. Being a good doctor involves more than simply being a good clinician. It means being committed to improving the quality of services and being willing to speak up when things are not right – that is not always easy, but it is at the heart of medical professionalism.”

Public Health Minister Anne Milton said they will continue to work with the GMC and other professional partners to raise standards on the frontline, and to protect those who draw attention to substandard practice.

The new guidance comes into effect on 12 March 2012. Read the guidance here: www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp. Also, see MPS’s factsheet on raising concerns and whistleblowing: www.medicalprotection.org.uk/uk-factsheets.
The Care Quality Commission (CQC) has revealed that it will be inspecting as many as 10% of GP practices because they pose a “significant risk of non-compliance”.

In an evidence session to the House of Commons Public Accounts Committee, officials from the regulator warned they expected a significant minority of practices to be at risk of non-compliance following registration, based on pilots run last year.

From 2013, GP practices will be required to state the functions they perform and self-assess compliance with CQC standards.

Amanda Sherlock, CQC director of operations, said that the CQC would “physically go” and inspect these practices – which would equate to more than 800 inspections in the first round of GP registration.

CQC chief executive Cynthia Bower said evidence from the pilots showed GPs were largely honest in confessing to non-compliance. She added if a practice declares itself compliant the CQC will obtain information on the practice from local sources, such as local primary care organisations or the GMC.

CQC GP registration lead Professor David Haslam said that non-compliance did not necessarily mean patients would be put at risk and they would be inspected.

“In some cases, GPs will have declared non-compliance, but will have told us what mitigating actions they will take. In these cases, we won’t necessarily inspect. We will, however, always inspect where we have evidence of poor care – but we don’t yet know for what percentage of this 10% this will be the case.’

Practices in England are required to register with the CQC from autumn 2012, and to register they will need to demonstrate compliance with CQC essential standards of quality and safety. Further guidance can be found in the MPS guide, Signposting the CQC: Understanding your new registration at www.medicalprotection.org/uk/booklets/signposting-the-cqc.

ONE TO WATCH

Patients will be able to choose which GP practice to register with, regardless of whether it is closest to their home, under a new pilot scheme starting in April. Health Secretary Andrew Lansley said the plan is just the beginning of a range of measures they hope to introduce to make the NHS truly patient-focused and to allow them to better understand patient needs. The year-long pilot scheme will begin in Westminster, City & Hackney, Tower Hamlets, Manchester, Salford and Nottingham City primary care trusts. MPS has serious concerns about the risk to continuity of care that this represents.

Source: GP

CAMPAIGN

The NHS has launched its first national bowel cancer symptom awareness campaign, Be Clear on Cancer sends the message that if you have “loose poo” or “blood in poo” for more than three weeks, it could be a symptom of bowel cancer and you should visit your doctor. It also says that catching cancer early makes it more treatable.

On behalf of the Department of Health, Bowel Cancer UK has developed a short factsheet to support GPs. To download this factsheet visit: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132047.

LEGAL UPDATE

A report into the government’s proposed reforms of the legal aid system has been published. Commissioned by the Law Society, Unintended Consequences: The Cost of the Government’s Legal Aid Reforms. A Report for the Law Society of England & Wales claims that cutting legal aid for those who have suffered clinical negligence would cost the government millions of pounds more than it would save. Visit: www.kcl.ac.uk/content/1/c6/08/81/08/UnintendedConsequencesFinalReport.pdf

USEFUL LINKS

The GMC has launched Your Health Matters, a new website for doctors who may be concerned about their own health or that of a colleague. The information is aimed at helping to provide timely information for doctors who may, for health reasons, be involved in fitness to practise procedures. It provides detailed information about what happens to doctors who are referred to the GMC where the concerns relate to their health. The resource includes case studies showing doctors with a range of health concerns, a testimonial from a doctor who has gone through fitness to practise procedures, and a range of advice on the process.

Visit: www.gmc-uk.org/concerns/11542.asp

CLARIFICATION

In the last issue of Your Practice we featured a triage protocol for non-clinical staff. Following a suggestion from one of our readers Dr Nicola Jones, a salaried GP from Buckley in North Wales, we have updated our protocol to include requesting contact details of the caller. This has been turned into a factsheet that can be downloaded from – www.medicalprotection.org/uk/your-practice-october-2011/ask-the-expert.
Some community pharmacists offer a repeat prescription request service at the pharmacy. Patients request their repeat prescriptions and the pharmacist arranges to deliver them, or prepares them for collection at the pharmacy. This has attractions both for patients, from a convenience point of view, and for pharmacists in securing business for the pharmacy.

Repeat prescribing is a major factor in the daily workload of GPs and practice staff. It is also a significant part of the workload for community pharmacists. Close co-operation between pharmacists and prescribers is helpful in ensuring efficient use of resources and encouraging patient compliance with medication.

Repeat prescribing in primary care is fraught with risk; this is partly due to the sheer volume of prescriptions. It is vital that the repeat prescribing process is as safe as possible. GPs and pharmacists should have written protocols for their respective repeat prescribing responsibilities (and in the case of pharmacists, for dispensing too). In addition, it is important that they follow the ethical guidance from their respective regulatory bodies. This case raises several potential concerns.

**Patient safety**
- If a patient appears to be regularly requesting medication, the GP may perceive that the patient is taking the medication. He may, in fact, not be taking as much medication as he is ordering, and this may give misleading clinical information to the GP.
- The volume of repeat medication received by a patient may cause him confusion, or he may become demoralised about the amount of medication, with the result that he does not take all of his medication.
- With increasing amounts of medication being received, the patient may be at risk of overdose, especially if he has visual impairment or confusion.

**Resource implications**
- Unused medication is costly to the NHS and a waste of resources. Once a box of medication is dispensed and leaves the pharmacy, it cannot be reused even if it is returned to the pharmacy.

**Possibility of fraud**
- Suspicions that the pharmacist may have been ticking all the boxes, when the patient only requested some of the items, may be correct.
ASK THE EXPERT

1. Arrange a further review to evaluate the situation. This concern and it is important that they may be reluctant to seek advice.

What should be done? There are several aspects to this concern and it is important to evaluate the situation.

1. Arrange a further review of the patient
   - It is good practice to regularly review elderly patients on more than four repeat prescriptions, and it is a GP contractual incentive that these patients have a medication review at least once a year. Such reviews should be conducted face-to-face in this age group and should include monitoring the usage and effect of medications, and assessing the continuing need for each repeat prescription.
   - Does the patient know how to take his medications? Are there any areas of confusion? Is he worried about running out of medication? How confident does he feel about the repeat prescription process?
   - Determine which prescriptions the patient actually requested from the pharmacist.
   - Are the medications synchronised so that all regular repeats run out and need ordering at the same time?
   - How much of his “as required” medication is he using? Consider issuing smaller amounts of analgesics to prevent stockpiling.

2. Talk to the community pharmacist
   - Seek the patient’s consent to discuss his case with the community pharmacist.
   - Discuss your concerns with the pharmacist. Explain that the patient appears to be stockpiling large quantities of “as required” medications. Explore how this has occurred and the mechanism by which the patient has been requesting his repeat prescriptions.
   - Consider whether it would be best for this patient to order his medications directly from the surgery so that you can keep a closer eye on what he is requesting.

3. Discuss this issue with the other GPs
   - This episode could be considered a “near miss”. Whilst no actual harm has occurred to the patient, it is possible that left unaddressed, he may have inadvertently taken too much medication.
   - Hold a significant event audit meeting involving all the other prescribers. How frequently did the patient request his repeat medication? Could the stockpiling of medications have been identified earlier by the practice?
   - Have other GPs had similar concerns about other patients? Does any action need to be taken within the practice to safeguard other patients? Consider conducting regular repeat prescribing audits.
   - If this is more than one isolated incident, you may wish to stop accepting repeat prescription requests from pharmacists.
   - Are there ongoing concerns about the conduct of this community pharmacist? If so, you need to consider referral to the General Pharmaceutical Council (GPhC).

4. Contact the local commissioning body (LCB) or primary care trust (PCT)
   - Check with the LCB or PCT that the system whereby pharmacists are allowed to initiate repeat prescriptions is an agreed system between the pharmacy, the LCB or PCT and the practice. Pharmacists may be putting themselves in a vulnerable position if there is a chance that the system could be misinterpreted.
   - If you have concerns that the pharmacist’s conduct may be putting patients at risk, then you need to take action (see GMC’s Good Medical Practice (2006) par 43).
   - Outline your concerns in writing to the appropriate person at the LCB or PCT, who are authorised to manage excessive prescribing (under the 2004 NHS Regulations for GMS and PMS GP Contracts and Terms of Service of Pharmacists in the NHS (Pharmaceutical services) Regulations 2005).

5. Refer the matter to the GPhC
   - If the PCT or LCB do not appear to take appropriate action, then you should refer the matter to the GPhC in line with Good Medical Practice (par 44).

USEFUL REFERENCES
- GMC, Good Practice in Prescribing Medicines (2008)
- GPhC, Standards of Conduct, Ethics and Performance (2010)
Unsung heroes or hidden risk?

There is much debate about what can be delegated to healthcare assistants. Julie Wilson and Dr Richard Stacey explore what HCAs should be doing.

Healthcare assistants (HCAs) are an “army of unsung heroes” who deliver outstanding care on a daily basis, said the Health Secretary Patricia Hewitt in 2005. Since the introduction of the new GP contract in 2004, the number of HCAs has boomed in response to the increased level of work. Following a 1988 position paper by the UK Central Council for Nursing, Midwifery and Health Visiting, the role of the healthcare assistant was one confined to undertaking clerical work and maintenance of the workplace for healthcare professionals. How times have changed. HCAs are now trained to undertake specified tasks that have been taught, assessed and delegated to them by registered health professionals, and play specific roles in clinical activities within the general practice team. The Working in Partnership Programme (WIPP) defines an HCA as “someone who works under the guidance of a qualified healthcare professional”.

Role of HCAs

In MPS experience, having undertaken clinical risk self assessments (CRSAs) across the country, the role of the HCA varies. HCAs undertake activities that range from routine clinical tasks, such as blood pressure monitoring and new patient checks, to more complex clinical tasks, such as venepuncture, vaccinations, ear syringing, warfarin monitoring, wound care and non-clinical work, such as record summarising. A far cry from 1988!

There is little guidance available for this expanding role and there appears to be little consistency in its development. However, this may change as last year the Health Secretary Andrew Lansley announced plans for a voluntary register, code of conduct, and basic training standards for HCAs. The government said it anticipated the work would be completed this year with the new standards available from 2013.

So what tasks can you delegate to an HCA?

There is no definitive list of tasks that an HCA can undertake. However, the role of the HCA is obviously different to that of a registered nurse. HCAs should be delegated tasks by registered clinicians, only after those clinicians have undertaken an assessment of the patient, so that the tasks are clearly defined. HCAs do not assess patients and if any task involves assessment, followed by a procedure, then it is not an appropriate job for HCAs, eg, undertaking cervical smears. Cervical cytology involves continued assessment of the patient during the procedure by the practitioner, and decision-making following the procedure as defined by the Skills for Health. On the other hand, undertaking vaccinations for influenza is a defined task being administered under a Patient Specific Directive.

The General Medical Council (GMC) states:

“When you delegate care or treatment you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to provide the care or treatment involved. You must always pass on enough information about the patient and the treatment they need.”

The Nursing and Midwifery Council (NMC) states:

“The delegation of nursing or midwifery care must be appropriate, safe and in the best interests of the person in the care of a nurse or midwife. The decision to delegate would be judged against what could be reasonably expected from someone with their knowledge, skills and abilities when placed in those particular circumstances.”
HCAs should be delegated tasks by registered clinicians, only after those clinicians have undertaken an assessment of the patient, so that the tasks are clearly defined.

MPS advice is whatever task is delegated to an HCA, the healthcare professional must ensure that the HCA is trained and has the necessary knowledge, skills and competence to undertake the tasks delegated to him/her, and that accountability is clear. The Royal College of Nursing (RCN) states that HCAs should be trained up to National Vocational Qualification (NVQ) level 3, in order that they can work independently.

Examples of specific tasks

1. Immunisations

Before delegating the administration of influenza vaccinations to an HCA you need to ensure that he/she is competent to undertake this task, ie, provide training and supervision; the latter by a qualified healthcare professional, ie, nurse or doctor.

Drugs can be administered under a Patient Specific Directive by an HCA (this does not mean that it is appropriate for all medications to be given this way by an HCA). The instruction is specific for a named patient, although it is not uncommon for it to be used to cover a list of named patients. The person administering the drug is not making any kind of assessment because under this direction, the practitioner (usually a doctor) who has written or signed off the direction, should have assessed the patient and therefore takes responsibility for the decision.

Anyone giving vaccinations must be trained to recognise and treat anaphylaxis. If an HCA was administering vaccines a doctor or nurse would need to be in the building. The Health Protection Agency has set out national standards and guidelines for training vaccinators. Page 7 of the document summarises the national standards:

1. Anyone who immunises or advises on immunisation should be on the relevant professional register, such as the NMC or GMC.
2. Anyone who immunises or advises on immunisation should receive specific training in immunisation and should attend regular updates.

2. Ear syringing

MPS supports "reasonable delegation", within the field of an HCA’s expertise, as long as they are fully trained, are competent and follow a robust protocol. MPS would expect that training had been validated locally or nationally. Of course, the employing GP partners are vicariously liable for the acts and omissions of the HCA. It is essential that if you do delegate ear syringing to an HCA you inform MPS to ensure that adequate indemnity cover is provided. MPS may ask you to confirm training and competency of the HCA. The Primary Care Ear Centre offers training on ear syringing – www.earcarecentre.com/training.htm.

3. Warfarin

It is important to have a robust protocol in place for monitoring those patients who are taking warfarin. This should be reviewed regularly and issues raised promptly addressed. It is essential that patients have a good understanding of their anticoagulant medication.

MPS does have significant concerns about the extended role regarding warfarin monitoring, where an HCA is making therapeutic decisions. If a claim were made following a wrong dosage, the employing GP partners would be vicariously liable for the acts and omissions of that HCA. It could be argued that an element of assessment should not be undertaken by an HCA, when dosing warfarin even when using an INR monitoring computer package.

If this task is delegated to an HCA, the following MPS advice should be in place:

- A warfarin clinic protocol for an HCA should address requirements for safe practice, such as history-taking, record-keeping and "safety netting", defining for example:
  - The minimum frequency of face-to-face review by the supervising doctor and the information to be recorded at a review (preferably using a computer template)
  - The training that the HCA should have completed initially and the required update training
  - The written information that must be provided to patients about issues such as interactions, lifestyle restrictions while taking anticoagulants and symptoms that might indicate dangerous warfarin dosages
  - The history items to be recorded by the HCA at each encounter (preferably using a computer template)
  - How patients’ responses to questions and their concerns should be recorded and dealt with

- Circumstances that must immediately and invariably be reported to the supervising doctor
- What should the HCA do if an INR is outside normal limits at the time of testing?
- Who is responsible for action if a patient cannot be contacted by phone by the doctor?
- Are procedures in place that prevent patients being “lost to follow up” if they miss an appointment with an HCA? (Some INR monitoring computer packages have a specific facility to flag non-attendees.)
- What audit arrangements are in place to monitor the clinic? Minimum audit requirements are usually specified in the Enhanced Service contracts that fund near-patient INR testing. The primary care organisation will usually require statistical returns about the spread of INR readings achieved in a primary care clinic. The PCO contract will typically also specify circumstances where they should be notified of significant or untoward incidents related to anticoagulation.

Indemnity

Within general practice, HCAs are required to work in situations where constant close supervision is not always possible. This means that HCAs need to be able to share in the responsibility for working safely and correctly. Education, training and assessment will help to give them the confidence to do this successfully.

All HCAs should have adequate indemnity arrangements in place for the task they undertake. It is essential that you inform the MPS membership department of tasks that the HCA is undertaking to ensure that adequate indemnity arrangements are in place.
Ms C, a healthcare assistant at Sunny Street Practice, had originally been a receptionist but was keen to expand her role. Five years ago, she underwent the appropriate training so that she could undertake the role of a healthcare assistant.

A couple of years ago the practice decided it would start running its own in-house anticoagulation clinic, and with this in mind, Ms C attended a training course that was run by the providers of a clinical decision support software package for the interpretation of INR results.

One of the practice partners drew up a protocol for the anticoagulation clinic, and it was agreed that Ms C should be allowed to run the clinic and make suggestions in relation to dosage changes in accordance with the advice provided by the clinical decision software; with the caveat that if she had any concerns that she should revert to one of the GPs for advice.

Ms C had been running the anticoagulation clinic without difficulty when she saw 64-year-old Mrs J, who had been taking warfarin for several years for the indication of recurrent deep vein thrombosis (DVT). Mrs J’s INR had been stable for some considerable time on a dose of 4mg of warfarin; however, on this occasion the INR reading was 1.5, which was below the therapeutic range.

Ms C confirmed that Mrs J had been regularly taking her medication and that she had not recently started any other medications (either prescribed or over the counter). In accordance with the advice provided by the decision support software package, Ms C suggested an increase of the warfarin dose to 6mg.

Three days later, Mrs J had an episode of melena and collapsed. Mrs J’s husband called the ambulance where she was resuscitated; however, when she arrived at hospital her INR was 8.5 and it was clear that Mrs J had sustained an upper gastrointestinal haemorrhage. Sadly, despite the hospital’s intervention, Mrs J passed away.

The postmortem demonstrated that Mrs J had died from an upper gastrointestinal haemorrhage precipitated by over-anticoagulation. Mr J subsequently pursued a complaint, from which it became apparent that in the several days prior to her appointment with Ms C, she had had several episodes of diarrhoea, which is likely to account for the fact that her INR reading was subtherapeutic.

Learning points

- Anticoagulants have been identified by the NPSA as a class of medicine that frequently causes preventable harm and admission to hospital.
- Given the potential risks associated with anticoagulation therapy, careful consideration needs to be given as to whether or not it is appropriate to delegate the task of running the anticoagulation clinic to an HCA.
- It is important that anyone running the anticoagulation clinic has the appropriate experience, qualifications and training.
- It is important to be aware of all the factors that may lead to a change in an INR reading and take time to consider any changes to the dosage regime.

REFERENCES

Clinical entries checklist

Good medical records facilitate effective handovers, reduce delays and misdiagnoses; they also protect against complaints or claims. MPS solicitor Louise Morgan provides a clinical entries checklist.

The General Medical Council (GMC) expects doctors to keep clear, accurate and legible records, which should be recorded at the same time as the events are recorded (or as soon as possible thereafter).

A good record should:
- Record relevant findings
- Record decisions made
- Record information given to the patient
- Record drugs prescribed
- Record other investigations or treatments prescribed
- Use abbreviations carefully, avoid using ambiguous abbreviations and/or those not universally recognised.

What comprises a medical record?
- Handwritten clinical notes
- Computer clinical notes
- Emails, faxes and text messages
- Scanned records
- Correspondence between healthcare professionals (correspondence to and from MPS should not form part of the medical record)
- Laboratory results
- X-ray films and other imaging records
- Photographs, videos and audio recordings
- Taped consultations

What makes a good medical record?
A good record will contain enough information to enable another clinician to easily take over the patient’s care and understand the possible diagnoses/investigations and/or treatment recommended or provided. The record will enable the new clinician to continue the care for that patient.

The record will also contain sufficient information to enable you to explain your thoughts and actions if a later claim or complaint arises, which often comes to light many years after the consultation.

Notwithstanding the primary need to ensure patient safety, good medical records can serve to protect you against future complaints and claims. A poor record can be sufficient to cause a doctor to have to settle a claim; conversely a thorough record may form the basis upon which a claim can be defended.

Structure of clinical entry
- Subjective – history
- Objective – examination
- Assessment – diagnosis
- Plan – management
- Information – patient involvement
- Follow-up – safety net

MPS is running medical records workshops across the UK throughout 2012. The Medical Records for GPs workshop aims to enhance doctors’ skills in keeping quality medical records. This three-hour workshop has been developed for GPs, and is available to members free of charge – the fee to non-members being £150.

For more information visit: www.mps.org.uk/workshops. On the MPS website you will also find a series of factsheets on medical records; visit: www.mps.org.uk/publications.

MPS Clinical Entries Checklist (GP)

Consultation details:
- Date
- Location/type of consultation
- Author/consulter
- Others present
- No ambiguous abbreviations
- Legible and understandable

History recorded:
- Presenting complaint/story
- Positive points
- Negative points
- Past medical history
- Risk factors
- Social/lifestyle history
- Family history
- Patient concerns
- Patient expectations

Examination recorded:
- Positive findings
- Negative findings
- Vital signs and measurements
- Chaperone where appropriate

Investigation(s) recorded:
- Results of investigations
- Planned investigations

Problem definition:
- Diagnosis/problem
- Differential diagnosis

Management recorded:
- Proposed management plan
- Options discussed
- Risks/benefits discussed
- Advice and information given to patient
- Agreed (or rejected) actions by patient
- Medication(s) prescribed
- Details of referral(s)
- Follow-up arrangements
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in any email that would allow a patient to be identified.

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