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Ireland

Professional support and expert advice for GPs and practice staff

MPS

Putting members **first**

VOLUME 1 – ISSUE 1 | MAY 2013

Don't be distracted

PAGE 6

THIS ISSUE...

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MPS EVENTS

Throughout 2013, MPS is involved in a wide range of events and conferences across Ireland.

- We attended the ICGP's AGM on 11 May, at the Radisson Hotel, Galway.
- MPS will be present at the ICGP Summer School at the Lyrath Hotel, Kilkenny from Thursday 20 – Saturday 22 June. MPS clinical risk programme manager Julie Price will be running two sessions on prescribing and medical records.

- On Thursday 12 September, MPS will be hosting its second General Practice Conference: Spotlight on Risk, at the Irish Management Institute in Dublin. Focusing on the top risks in general practice, topics will include the patient experience, CPD, and how MPS manages claims. Last year's event sold out, so register early to secure your place! www.medicalprotection.org/ireland/events/gp
- MPS will be on site at the Distance Learning Educational Workshops with the ICGP at the IMI in Sandyford from 27 to 28 September.
- We will be attending the National Primary Care Conference 2013 at Newbridge Primary Care Centre on Wednesday 13 November.
- Don't forget that MPS runs a series of *Mastering* workshops free of charge as a benefit of membership, on topics including risk, adverse outcomes and difficult interactions with patients. MPS also runs workshops specific to GPs, including *Understanding Human Error in General Practice* and *Medical Records for GPs.*
- New workshop dates have now been released for the second half of the year. For more information and to book your place visit: www.medicalprotection.org/ireland/education-and-events/workshops.

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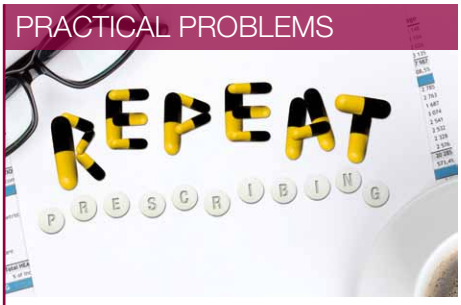
What's inside...

MEDICOLEGAL

4 Update

Top risks in general practice and new fitness to drive guidelines

PRACTICAL PROBLEMS



5 Checklist: Using chaperones to reduce risk

Does your practice have a chaperone policy? This handy checklist helps to highlight any potential risk areas

CAREERS

10 Core skills series: Communication

In this series we explore the key risk areas in general practice. These pages highlight key risks around communication that exist in the consultation room

HOME

Meet your Regional Membership Co-ordinator: Rachel Lynch

Rachel has worked in the Marketing Department at MPS 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 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** or at **Rachel.lynch@mps.org.uk**

Get the most from your membership...

MPS

Visit our website for publications, news, events and other information: **www.medicalprotection.org**

Follow our timely tweets at: **www.twitter.com/MPSdoctors**

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Welcome

Dr George Fernie – Editor-in-Chief, MPS Senior Medicolegal Adviser

Welcome to the very first edition of *Practice Matters Ireland*, a magazine for the whole practice team.

Merging MPS's GP publications, *Your Practice* and *GP Trainee, Practice Matters Ireland* aims to provide practical tips on risk management and medicolegal issues for your whole practice, whether you are single-handed or part of a large clinic.

MPS has identified the top ten risks in general practice based on the Clinical Risk Self Assessments (CRSAs) we carried out in practices throughout the UK and Ireland in 2012.

In this edition, we look in more detail at some of these common risk areas including: how to reduce risk when repeat prescribing on page 6; staff training and medicines management protocols for practice nurses on page 8; and how to set up a chaperone policy on page 5.

We focus on the most common risk area in general practice – communication – as part of our careers section, which begins on page 10.

We also consider the often-overlooked role GP locums can play in helping to reduce risk in your practice, by providing a fresh pair of eyes to spot any potential medicolegal pitfalls.

We hope you enjoy this edition and would be interested to hear your comments, as well as any topics you would like us to feature in future editions.

MPS update

MPS identifies top risks in general practice

MPS has identified the top ten risks in general practice, based on data collected from more than 120 general practices in the UK and Ireland as part of MPS Clinical Risk Self Assessments.

As technology is transforming the lives of many GPs and patients, from text appointment reminders to patients, to self check-in at practices, it is also becoming a risk area.

Julie Price, clinical risk programme manager at MPS, says: "In reviewing the top risks for 2012, issues around communication, confidentiality and prescribing were still the most pressing, but we also noticed a growing theme where technology was contributing to the risks in these areas.

"It's great to see that practices and patients are embracing technology as a way of gaining greater convenience and flexibility, however in the hurry to become digitally-savvy, it is important that they manage the associated risks."

MPS recently conducted its 1000th CRSA at Dr Fletcher & Partners GP Practice in Ripon, North Yorkshire, UK (pictured).

For further information visit: www.medicalprotection.org/ireland/crsa-gp

Percentage of practices who identified the risk

Communication	99%
Confidentiality	96%
Prescribing	96%
Record keeping and visits	96%
Health and safety issues	96%
Test results	88%
Infection control	85%
Staff training	84%
Protocols	79%
Appointments and access	78%

REPORTING UNSAFE DRIVERS

Ireland's first *Medical Fitness to Drive Guidelines* from the RCPI set out a doctor's ethical – and potentially legal – obligation to advise patients when their illness or injury may affect their ability to drive safely. **www.rcpi.ie**

Checklist: Using chaperones to reduce risk

"All patients must always be treated with respect for their dignity."
Medical Council, *Guide to Professional Conduct and Ethics*

Using chaperones helps to safeguard patient dignity and allows a doctor to fulfil their responsibility to maintain professional boundaries. But not all practices use chaperones appropriately, all of the time. MPS conducts Clinical Risk Self Assessments throughout the UK and Ireland. In 2012, 46% of practises we visited had an issue with training chaperones. Forty per cent of practices we visited did not have a chaperone policy in place, and of those that did, 24% applied their policy inconsistently.

A chaperone:

- Adds a layer of protection for a doctor – it is very rare to receive an allegation of assault if you have a chaperone present
- Acknowledges a patient's vulnerability
- Provides emotional comfort and reassurance
- Can act as an interpreter.

Who should be a chaperone?

Although chaperones do not have to be medically qualified, they must be trained. In 46% of practices MPS visited, poorly-trained chaperones were identified as a risk area, eg, some practices were using untrained receptionists.

Chaperones must be sensitive to the patient's confidentiality; be prepared to reassure the patient; familiar with the procedures involved in an intimate examination; and prepared to raise concerns about a doctor if misconduct occurs.

Ideally, family members or friends of both the patient and the doctor should not be a chaperone – they may not fully appreciate the nature of the physical examination performed, and they may not be completely impartial.

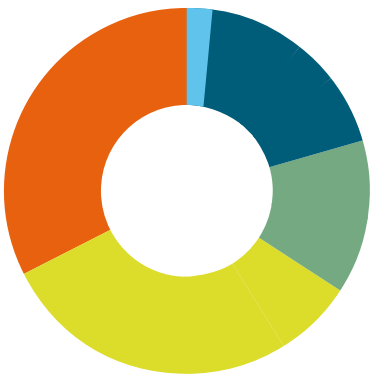
What if a chaperone is not available?

On a home visit, or in an out-of-hours setting, a chaperone might not be possible. In such circumstances, you should consider whether the examination is urgent on a clinical basis. If it isn't, you could rearrange the appointment for a time when a chaperone is present.

If the examination is urgent, but hospital admission is not indicated on the history alone, there may be occasions when a doctor goes ahead in the absence of a chaperone. In such circumstances, obtain and record the patient's consent. In addition, record the fact that the patient was examined in the absence of a chaperone, along with the clinical reasons why.

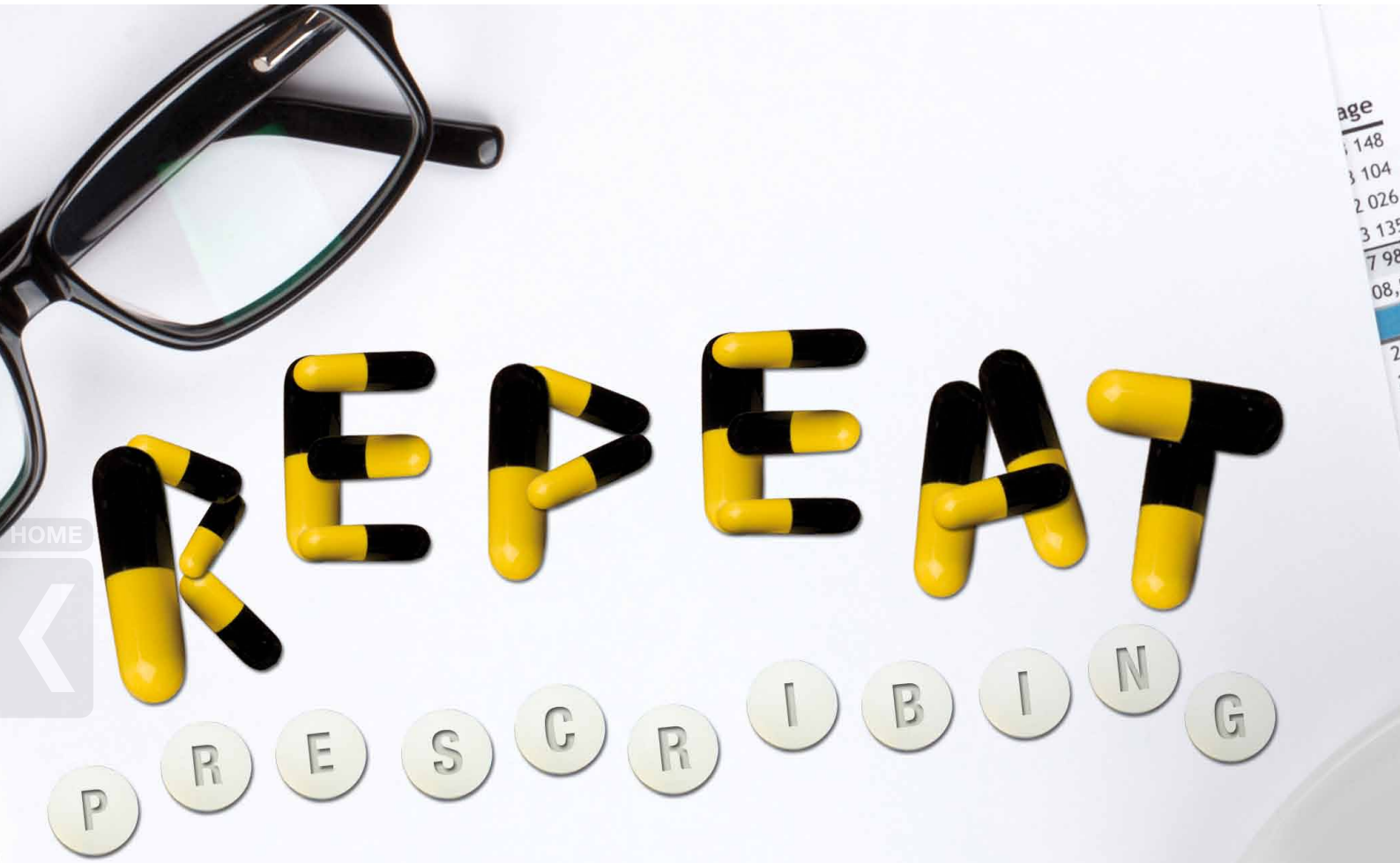
Further information:

Medical Council, *Guide to Professional Conduct and Ethics* (2009)



How to use a chaperone:

- ✓ *Before performing an intimate examination, explain what the examination will entail, and explain why it is necessary – provide an opportunity for the patient to ask questions.*
- ✓ *Obtain and record the patient's consent.*
- ✓ *Offer a chaperone to all patients for intimate examinations (this can also extend to examinations where it is necessary to touch or be close to the patient, eg, conducting eye examinations in dimmed lighting). If the patient does not want a chaperone, record this in the notes. (Eighteen per cent of practices MPS visited did not write whether a chaperone was offered and accepted/declined in a patient's records).*
- ✓ *If the patient declines a chaperone and as a doctor you would prefer to have one, explain this to the patient and, with their agreement, arrange for a chaperone. Doctors do not have to undertake an examination if a chaperone is declined.*
- ✓ *Give the patient privacy to undress and dress. Use paper drapes where possible to maintain dignity.*
- ✓ *Explain what you are doing at each stage of the examination, the outcome when it is complete and what you propose to do next. Keep the discussion relevant and avoid personal comments.*
- ✓ *Be sensitive to a patient's ethnic/religious and cultural background.*
- ✓ *Record the use, offer and declining of a chaperone in the patient's notes.*
- ✓ *Record the identity of the chaperone in the patient's notes.*
- ✓ *Record any other relevant issues or concerns immediately after the consultation.*
- ✓ *Keep the presence of the chaperone to the minimum necessary. There is no need for them to be present for any subsequent discussion of the patient's condition or treatment.*



Don't repeat the risk

Cork-based GP Dr Diarmuid Quinlan and pharmacist/GP intern Dr Paul Ryan provide some top tips on avoiding errors when repeat prescribing

Is this a familiar scenario in your practice?

Busy receptionist answers phone: Mary Murphy wants her "usual tablets". Receptionist writes a long list of medication on a sticky note while trying to avoid eye contact with another patient standing before her, though it's difficult to hear over the radio blaring in the crowded waiting room. GP hovers impatiently at her shoulder with an urgent request. Later, the receptionist finds time to generate the repeat prescription, trying to remember exactly which of the four Mary Murphy's on the practice list actually phoned. Adds script to the large pile awaiting GP's signature. GP is running late, and quickly signs a bundle of repeat prescriptions between consultations (without the "usual rigorous" checking!). One in 550 repeat prescriptions contains a serious error.[1] Could this be you?

Repeat prescribing can be a win-win situation: good for patients and good for doctors. It is convenient for patients and practices can experience a more structured workload, fewer "urgent" requests, fewer phone calls and less traffic at reception.

Repeat prescribing has been described as: "A partnership between patients and prescriber that allows the prescriber to authorise a prescription so it can be repeatedly issued at agreed intervals, without the patient having to consult the prescriber at each issue." However, "The authorising prescriber must ensure that arrangements are in place for any necessary monitoring of usage and effects, and for the regular assessment of the continuing need for the repeat prescription."[2]

Repeat prescribing accounts for some 75% of prescriptions issued in general practice, with approximately half of all patients receiving repeat prescriptions.[3] One in eight patients has prescribing or monitoring errors in their repeat prescription.[1]

There are none so blind as those who will not see

Repeat prescribing is a deceptively complex process, involving over 20 steps – from the

initial decision to prescribe, to the patient finally swallowing the medication.[2] Errors can, do and will arise at any of these steps. 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. Ultimately, the doctor that signs the prescription is legally responsible. If you think you don't make mistakes in your repeat prescriptions, you're probably wrong. These unseen errors, or "unknown unknowns", pose a great risk to patients and physicians. Ask your pharmacist for prescribing errors you make this month – it will make for sober reading!

Why this medicine?

The clinical indication for a repeat medication should be explicitly documented in the patient record. Kill two birds with one stone: audit your repeat prescriptions for safer prescribing and fulfil your CPD audit requirement at the same time. You could audit warfarin; audit four parameters, eg, date commenced, clinical indication, target INR and duration of therapy; or audit methotrexate monitoring.

How – and when – do patients request repeat prescriptions?

Written requests are far preferable to verbal requests; the opportunity for error is reduced. Most practices still accept telephone requests. Many practices have a designated receptionist with protected time in a quiet location to prepare repeat prescriptions. This can prove efficient while reducing potential for error. Electronic requests are fast approaching..."Bí Ullamh".

"*Can't I just wait for the doctor to sign it?*" Sound familiar? Patients need to know how your repeat prescribing system works. Use every available opportunity to educate patients about why it takes three days to safely prepare and rigorously check the prescription. The receptionists, pharmacists, GPs, practice website and leaflets should all reinforce the process. We all make dental and hairdresser appointments well in advance; surely patients can request medication in a timely fashion! I ask for three working days' notice. It's really important for others in your team not to undermine this timeframe by suggesting it will be ready "later today".

Ensure appropriate clinical review

In your practice, is clinical review usually an "ad hoc" opportunistic review, or a systematic review of the patient, their illness and management? A useful strategy is to issue sufficient medication until the next clinical review is due – this reduces the number of repeat prescription requests. Patients requesting repeat prescriptions either early or late should raise concerns about possible overuse or underuse of medication. Synchronising the clinical review and quantity of medication issued is highly convenient for patients and the practice.

Signing the prescription

The doctor signing ideally both knows the patient and has direct access to the patient file. You must be confident the medication is appropriate, and that all necessary monitoring is undertaken. What happens when you're on holiday? Is the locum placing both patient and practice at risk?

The primary-secondary care interface

What happens when medication changes are recommended upon discharge or from hospital OPD? How do you manage prescribing based on recommendations of a hospital consultant? For patients discharged from public hospitals, pharmacists "are authorised to dispense up to a maximum of seven days' supply" in certain circumstances.[5] Who amends the patient file? Only the GP should add, delete or amend medications. Doctors should never ask, expect, or allow the secretary to do this. When should changes be made? Medication changes should be made upon receipt of the hospital letter. The UK GMC recommends that "any changes to the patient's medicines are critically reviewed and quickly incorporated into their record".[6] How do you notify drug changes to the pharmacist? Do you just delete the unwanted medication, or amend the dose? This may result in a phone call from a concerned pharmacist. What about explicitly writing "*Atenolol discontinued*" or "*Ramipril dose increased*" on the script? This may avoid unnecessary phone calls from an astute pharmacist, while enhancing clinical governance.

Uncollected prescriptions

What happens in your practice? Do they languish at reception, or are uncollected scripts systematically returned to the prescribing GP for review?

The pharmacist

Is your pharmacist a source of inconvenient phone calls or an esteemed colleague? You may be just one step away from a serious prescribing error. Pharmacists are ideally qualified to monitor compliance, encourage appropriate monitoring and identify drug interactions. Our repeat prescribing protocol states: "We greatly value the support and vigilance of our pharmacy colleagues. A pharmacist phoning with a medicine query should always be put through to the appropriate doctor."

A win-win situation

Is repeat prescribing in your practice a high-quality, seamless, safe service for patients, harnessing the unique skills and knowledge of all staff in the process? Or is it a high-risk, error-prone, "ad hoc" activity? Your practice, your patients, your reputation, your decision. Make your repeat prescribing a win-win situation.

HIGH-RISK PATIENTS AND HIGH-RISK MEDICINES

Medication errors make up a fifth of all errors occurring in general practice, and many of these are preventable. Some patients are especially likely to experience serious adverse events due to repeat prescribing errors.[2] These include:

- Patients over 65 years and under 16 years of age
- Patients on four or more medicines
- Patients recently discharged from hospital and/or attending hospital outpatient departments. The primary-secondary care interface is especially hazardous.

All medicines are equal, but some are more hazardous than others. Some medicines frequently cause serious harm, warranting special care and rigorous monitoring, including:

- NSAIDs
- Benzodiazepines
- Oral and topical steroids
- Oral contraception
- Anti-depressants
- Opiates
- Potentially toxic medicines: methotrexate, DMARDs, lithium, azathioprine, warfarin, "biologics."

You should assess your current repeat prescribing protocols and audit methotrexate and lithium monitoring to expose previously unrecognised risks.

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Practice nurses – practise safely

The role of nurses working within general practice is changing. MPS Clinical Risk Programme Manager Julie Price looks at these new responsibilities – and the potential risks they present

The practice nurse's role is developing in response to the Department of Health and Children's strategic plans to make primary care the first point of contact for a person needing healthcare.[1] Plans to abolish fees for GP care and focus on the prevention of illness and management of chronic diseases will involve the development of the whole primary healthcare team.

According to the Irish Practice Nurses Association (IPNA), there are approximately 1,700 practice nurses in Ireland;[2] a sizeable number given that there are approximately 3,500 GPs. 211 practice nurses are accredited as clinical nurse specialists (CNS), two have been accredited as advanced nurse practitioners (ANP) in primary care and 11 IPNA members are now registered nurse prescribers. Practice nurses are privately employed by GPs and must be registered general nurses (ie, on the live active RGN or PHN Register of An Bord Altranais, the nursing board).

Practice nurses now represent an important part of healthcare services in general practice: undertaking immunisations, cervical cytology, screening, health promotion, phlebotomy, weight management, smoking cessation, women's health, men's health, wound management, travel vaccinations, ear care, and management of chronic conditions such as asthma, COPD, and diabetes.

Challenges

As the role of the practice nurse has expanded, so too have the associated risks. Many nurses work in isolation, managing their own workload, and this in itself presents risks to safe and effective practice, especially when coupled with the inconsistent and variable opportunities for formal education and training to support practice beyond initial registration. MPS has seen a steady rise in the number of claims relating to general practice, some of which involve nurses. Being aware of potential risk areas can help to reduce the likelihood of a complaint or claim being made.

Maintaining competence

Primarily, nurses should only practise within their own competence areas to minimise the potential for error. An Bord Altranais states: "The nurse or midwife must make a judgement as to whether he/she is competent to carry out a particular role or function. The maintenance of competence and ensuring its continuing development is achieved by engaging in continuing professional development."[3]

Continuing Professional Development (CPD) enables practice nurses to provide evidence-based, up-to-date, quality care. CPD is essential before undertaking extended nursing roles and is required by An Bord Altranais. Practice nurses should keep a record of all CPD activity they undertake and keep up-to-date with clinical and regulatory guidelines.

It is essential that nurses are trained and competent to undertake procedures delegated to them, for example, cervical cytology and ear syringing. It is not enough to "see one, do one", ie, observe a colleague and then undertake the procedure.

Medication protocols

Of the 92,726 nurses registered with the nursing board in Ireland, only 532 are nurse prescribers.[4] Practice nurses who are not nurse prescribers, and who are administering medication without a named prescription, should use medication protocols. These are written directions that allow for the supply and administration of a named medicinal product by a nurse in identified clinical situations. A medication protocol involves the authorisation of the nurse, by the GP, to supply and administer a medication to groups of patients in a defined

situation, which meets specific criteria. An individually named prescription is not required for the supply and administration of medication when a medication protocol is in effect.

An Bord Altranais supports the developments of medication protocols using a nationally recognised template based on international evidence and best practice.[5] The legislative basis for medication protocols for the supply and administration of medication is the Medicinal Products Regulations of 1996 and 2003 (Prescription and Control of Supply).

Immunisation and vaccinations

Practice nurses are key health professionals involved in providing immunisations to the community in the promotion of public health and prevention of infectious diseases. Examples include childhood immunisation programmes, seasonal vaccinations, occupational health vaccinations and travel vaccinations. Practice nurses should be using medication protocols for the administration of vaccines. However, in MPS's experience, very few do so.

Nurses should only practise within their own competence areas

Parents will normally consent to have their children included in the Health Service Executive national immunisation programme, but this does not mean that they have given their consent to all immunisations.[6] Parental consent is required for the administration of vaccinations to children and young people up to the age of 16. There should be a practice policy on whether consent is written. Nurses should ensure that consent is obtained for each vaccine given, from the parent or guardians, at the time of the immunisation.

Nurses should also ensure that they keep up-to-date with current practice in immunisation, including recognition and intervention with side-effects, treating anaphylaxis,[7] adverse events and/or complications post-immunisation.

When administering travel injections and other immunisations, the nurse administering the injection should note in the patient's record:

- The name of the injection
- Batch number
- Expiry date
- Mode of injection
- Site of injection.

Medical records

It is important that medical records include enough detail to justify the proposed management of the patient's condition. Maintaining complete contemporaneous records can provide evidence of care and/or treatment given, enable one member of the team to take over where another left off and can prove invaluable in defending a complaint or claim.

In *Recording Clinical Practice Guidance to Nurses and Midwives* An Bord Altranais states: "The quality of records maintained by nurses and midwives is a reflection of the quality of the care provided by them to patients/clients. Nurses and midwives are professionally and legally accountable for the standard of practice which they deliver and to which they contribute. Good practice in record management is an integral part of quality nursing and midwifery practice."[8]

Chronic disease management

Many practice nurses are now taking on responsibility for chronic disease management. It is particularly important that nurses have protocols regarding the management of these patients and set guidelines regarding referral onwards.[9] The use of evidence-based clinical protocols and agreed standards helps to ensure that nurses have a consistent approach to the management of chronic disease. Management of chronic diseases in primary care will increase over the next few years and now is the time to ensure that clinical protocols are in place. The DOHC will work with the HSE to introduce chronic disease management programmes between 2013 and 2015.

Vicarious liability

Vicarious liability is an important legal principle. In the case of a GP practice, it is the liability a GP may have for the acts and omissions of an employee or some other individual for whose conduct they are legally responsible, eg, practice nurses.

Although assistance is always at the discretion of MPS Council, it is likely that a GP would be granted assistance with requests related to claims of negligence against any of their employed nurses working at a basic level. Though it is unlikely that GPs would be granted assistance for such claims against nurses working in extended roles and/or at a more autonomous level, eg, nurse practitioners. For this reason, all practice nurses should ensure that they have their own appropriate indemnity. MPS can provide indemnity for practice nurses.

A Guide to MPS Membership provides more information on vicarious liability: www.medicalprotection.org/ireland/membership/guide

Summary

As a nurse's clinical responsibility increases, so too does this risk of an adverse event. But by understanding the common pitfalls, ensuring the correct protocols are in place, and continuing professional development, the margin for error can be dramatically reduced. Above all, practices must ensure that all staff they employ have adequate and appropriate indemnity.

Julie Price is speaking on medication protocols at this year's MPS General Practice Conference: Spotlight on Risk, being held at the IMI, Dublin, on Thursday 12 September. For more information visit: www.medicalprotection.org/ireland/events/gp

MEDICATION PROTOCOLS

Protocols define areas of responsibility and are documentary evidence of the standard of care provided. There is a danger that protocols may be developed by one individual in isolation, resulting in a lack of ownership for the rest of the practice team, and protocols that are rarely followed and only occasionally updated. Protocols should:

- Be discussed and agreed by the relevant practice teams
- Involve relevant representatives from different parts of the practice (eg, doctor, nurse) in their development
- Be revised regularly, eg, annually, and amendments made if necessary
- State the date they came into effect
- Be easily accessible to all relevant members of the practice team.

Out-of-date protocols should:

- Record the date they are withdrawn
- Be stored for at least eight years, because litigation can occur many years after an event.

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CORE SKILLS SERIES

Communication

In this series Charlotte Hudson explores the key risk areas in general practice

At a glance

In general practice communication has to extend to a greater number of people, so there are more opportunities for it to fail. Communication between primary, secondary, voluntary and social care should be viewed not as a chain, but as a communication net.

Prescribing

Good communication is particularly important when it comes to prescribing. Patients need to be made aware of, and recognise, adverse side effects.

It is vital that prescriptions are written clearly and accurately, and computer-issued prescriptions are properly checked. The *Irish Medicines Formulary* (IMF) offers some good advice on this. It is also important that the patient understands clearly what the medication is for, and how they should take it.

Check what other medication the patient is taking, and whether there are any contraindications with the current prescription.

Colleagues

You and your colleagues should be aware of who is doing what, and understand the part they play. This will involve sharing patient information, which is entirely appropriate as long as continuity of care is balanced with the need to maintain confidentiality. The Medical Council's *Guide to Professional Conduct and Ethics* states: "Doctors working in multidisciplinary teams should ensure that there are clear lines of communication and systems of accountability in place among team members to protect patients."

Working as a locum GP, your colleagues should provide all the relevant details of the patients for whom you are responsible. Practices should have in place protocols for the transfer of relevant information between doctors. However, many do not cater for the nuances of working as a locum, so locums should have in place their own systems to ensure adequate clinical handover.

Consultations

Average consultation time in Ireland is about 15 minutes per consultation. In this time you will need to establish a good relationship with the patient, communicate effectively, and make an accurate diagnosis. Research shows that a focused history and examination will indicate the diagnosis in about 75-80% of cases. Good communication with patients during a consultation is your first line of defence in warding off complaints and potential clinical negligence claims. Effective interpersonal skills are particularly important for locum GPs because they often have only one chance to make a good impression.

Patients who are denied the opportunity to explain their concerns or reasons for presenting may feel alienated, frustrated or resentful. Patients who are kept informed about their condition, and who are actively involved in deciding on the appropriate treatment, are more likely to comply with suggested treatments and are less likely to complain if things go wrong.

Tips for an effective consultation:

- Let the patient talk first. An uninterrupted history aids diagnosis.
- Use non-verbal communication to encourage patients to talk, eg, nodding, making and maintaining eye contact.
- Well-aimed open questions can help "lead" the consultation.
- Allow patients enough time to ask questions and clarify things
- Use patient information leaflets or factsheets. www.patient.co.uk is a useful resource.

Using computers

It is important that the patient feels that they are receiving your full attention. Two helpful approaches are:

- Listen – if the patient speaks, stop what you are doing and turn your attention to them – providing a useful opportunity for the patient to reflect and tell you any information they have forgotten.
- Explain – tell the patient what you are doing.
- You should ensure that other people cannot overlook your screen and make sure that when you are talking to a patient you have their records displayed and not someone else's. There is nothing to prevent you letting a patient see their own records, unless these include information relating to a third party.

Being open when things go wrong

Sometimes, in spite of your best efforts, patients will be unhappy with the care they have received. The Medical Council, in *Guide to Professional Conduct and Ethics* (2009), states: "Patients and their families are entitled to honest, open and prompt communication with them about adverse events that may have caused them harm."

An apology goes a long way in defusing a situation, and is not necessarily an admission of liability. Where there are differences of opinion between you and a patient, or a patient's relatives, there is much to be gained and rarely anything to be lost by the expression of regret by the doctor.

Telephone consultations

Studies show that public satisfaction with telephone consultations is high, and patients increasingly wish to have this option. Talking to a patient on the phone, however, exaggerates the difficulties of a face-to-face consultation because there are fewer cues to pick up on.

- During telephone consultations, the Medical Council warns: "Doctors must pay attention to issues such as record-keeping and confidentiality." Be cautious about revealing your identity until you have confirmed that you are speaking to the patient. You should only discuss details with a friend or relative if you are sure that the patient has given their consent.
- Empathise with the caller.
- When gathering information on the caller's problem, make sure you: ask some open questions and closed questions, ensure that you are in a position to reach a sound clinical judgment, agree a plan of action with the patient, and check that they agree with it and understand it.
- Ask the patient to repeat the advice given several times throughout the consultation.
- Document the consultation accurately.
- Follow-up: check existing medication when prescribing new medication, explain to patients what they should expect by way of improvement, significant symptoms to report, or when to phone back if they are not getting better.
- Be aware that a common error is to record information or prescribe in the wrong patient file as another file has been called up during the consultation – always check.

USEFUL LINKS

- Medical Council, *A Guide to Professional Conduct and Ethics* (2009) www.medicalcouncil.ie/Registration/Guide-to-Professional-Conduct-and-Behaviour-for-Registered-Medical-Practitioners.pdf
- MPS communication workshops, on *Mastering Professional Interactions* and *Mastering Adverse Outcomes,* www.medicalprotection.org/ireland/education-and-events/workshops
- MPS E-learning platform, www.medicalprotection.org/ireland/education-and-events/elearning
- MPS factsheet, www.medicalprotection.org/ireland/factsheets/communicating-with-patients-by-fax-and-email
- MPS General Practice Conference 2013: Spotlight on Risk, www.medicalprotection.org/ireland/education-and-events/conferences-and-events

Dr John Paul Campion, a GP registrar from Mid Leinster, knows all about the importance of having a clear head during consultations

As a trainee GP, the communication issues that you deal with are entirely different to those faced in the hospital setting. The patients are coming into your working space and bringing their issues and agendas. However, as a doctor, being aware of your own issues is equally as important for effective communication.

Recently, I saw a difficult patient during a morning session. He and his wife, who both didn't speak very good English, were demanding an antibiotic for an apparent viral illness, and despite my best efforts I could not convince them otherwise. After a prolonged exchange I felt left with no alternative but to prescribe the antibiotic. Naturally, once the consultation was over I had a mix of emotions; anger and frustration were at the forefront of these. There were lessons to be learned – but the biggest came just a few minutes later.

I called my next patient in, a 16-year-old boy accompanied by his parents, and began as I would any consultation by asking why they had come in. A very emotional mother began explaining how she had been called into the school by the principal to discuss some worrying texts sent by the boy to his friends over the weekend suggesting that he was planning to take his own life. His grandfather had died by suicide a year ago and a close friend by the same means some three weeks previously.

As is my usual routine, I had begun taking notes and she took exception to this, perhaps feeling my full attention was not on her problems. Still pumped full of adrenaline from my prior patient encounter I was defensive of my actions initially…but thankfully realised my position and changed my approach given her evident upset. Having done this, the rest of the consultation proceeded well. I spoke with the boy on his own for a few minutes and again with his parents present and came to understand the situation better. They left with a clear plan in place to liaise with local psychiatric services that afternoon and were clear that they could return at any time to speak with me again.

The main lesson I learned was that you never know what the next patient brings. It is vitally important to finish one consultation before beginning the next, both physically and mentally. Roger Neighbour, in his 1987 book, *The Inner Consultation*, called this 'housekeeping' and it means being sure that you are in the right shape to see the next patient. Easier said than done in a busy clinic setting, but essential to prevent communication breaking down before the patient even enters the room.

Test your knowledge

Try out the mock questions below and test your knowledge.

1. A patient is angry about the long wait he has had before getting an appointment. He challenges you about it, raising his voice and making threatening gestures. What do you do?

A – Challenge his behaviour and raise your voice.

B – Ask about the cause of the problem, speaking calmly and slowly and attempting to resolve the situation.

C – Refuse to treat the patient and make steps to have him removed from the practice list.

2. A 68-year-old patient with moderately severe dementia attends surgery. His symptoms have been getting worse and he has had two minor driving collisions recently. He does not understand that it might be dangerous to keep driving, and seems confused. What should you do?

A – Inform the RSA about this patient's condition.

B – Ask the patient to contact the RSA and inform them of his condition.

C – Request another hospital appointment for assessment of his fitness to drive.

For the answers to these questions visit the *Practice Matters Ireland* section of the website: www.medicalprotection.org/ireland/practice-matters-issue-1/test-your-knowledge

Also, visit the MPS E-learning section of the website where you can access a number of interactive case reports on communication skills and earn CPD points too. http://www.medicalprotection.org/ireland/education-and-events/elearning

In the Hot Seat

This issue...

Newly appointed ICGP Network of Establishing GPs (NEGs) Programme Director Dr Peter A Sloane shares with Charlotte Hudson his plans for the future of the Network

HOME

The NEGs Programme, set up in 2004, identifies the needs of GPs fresh out of training and provides them with advice and support.

On 1 February, Dr Sloane took over the reins from outgoing NEGs Director Dr Mary Glancy after a three-month handover period, giving him the opportunity to learn from and take advantage of the expertise, knowledge and experience of Dr Glancy.

Dr Sloane says: "I hope that over the next 18 months to two years we can move away from the idea that NEGs is a separate group within the ICGP towards being more focused on the service that we deliver, largely to establishing members of College. Although trainees automatically become members of NEGs on entering fourth year, I hope to increase awareness."

Key issues for new GPs

The Network provides establishing GPs with advice and support on issues such as finding work, different types of work (eg, locum work, sessional work, assistantship) and access to continuing medical education (CME). In Ireland, there is a system whereby most GPs will be a member of a small CME group, which meets monthly to discuss ongoing educational and support needs. Access into these groups can be quite challenging for people who are starting out in College and the NEGs Programme provides support.

The Network also advises establishing GPs on how to set up in practice, whether through partnership or setting up on their own, and helps members appreciate the mechanisms and implications of access and non-access to a General Medical Services (GMS) contract. They also advise on contracts of employment.

They are currently developing connections between retiring and establishing members in relation to topics such as practice succession. "There are a number of issues that we advise on which not only affect establishing members but all GPs in general," Dr Sloane explains. "There will be a significant degree of uncertainty within general practice over the coming years – GPs have experienced an overall reduction in incomes, there are higher expectations and demands from patients, and the government in Ireland is intending to roll out universal health insurance, which will have a significant impact on general practice."

Focusing on the needs of establishing members

NEGs runs local regional meetings twice a year for members delivered by regional representatives. The meetings are based on topics of interest to establishing GPs, and are a forum through which information is delivered.

"My vision is for these meetings to develop over the next 12 to 18 months so that they provide a much more robust vehicle for establishing members to feed back their issues and concerns into College, where action can be taken to address them," says Dr Sloane.

Dr Sloane is running a workshop session at the ICGP AGM in May, which will give establishing members the opportunity to express any issues they have with the ICGP.

A valued and popular element of the NEGs Programme is the access that members have to an online discussion forum, with threads relating to both clinical and non-clinical issues. It provides a peer to peer resource for NEGs members. Clinical queries include such conundrums as where to refer patients with unusual symptomology, and seeking opinions on management options. Non-clinical threads include the recent Medical Council elections, financial aspects of practice, and Emergency Department waiting times.

Mentor network

The ICGP aims to establish a "mentor network" that doctors will be able to access if they need personal advice and support in relation to complex and difficult issues in practice. Look out for updates on this in the coming year.

Tips from Dr Sloane:

- **Enjoy your job – Being a GP and an active member of the ICGP is an opportunity to have a lifelong involvement in a professional supportive organisation that is in many ways like an extended family.**
- **Think strategically about changes that are happening within general practice and within healthcare in Ireland.**

Getting involved

One of the objectives of the Network is to work to overcome barriers to younger GPs participating in the College and encourage them to get involved.

Dr Sloane says: "Establishing members will, after a relatively short time in practice, become core members of the ICGP. We believe that the College is enriched and strengthened by the talent and energy of establishing GPs. Through establishing GPs getting involved and having their voices heard, College will continue to recognise concerns and ensure that services and supports are in place to address them."

Dr Sloane, along with Dr Rita Doyle, past President of the ICGP, is developing connections between retiring and establishing members in relation to topics such as practice succession. He explains how it is important that a GP who is looking to retire knows how to go about discussing succession with establishing GPs who may be thinking about partnership or the idea of succession.

Assessing capacity

MPS Medicolegal Adviser Dr Sonya McCullough clears up some common grey areas for GPs

Can I prescribe contraception to a patient under 16?

Amy, a 15-year-old girl, attends her GP surgery alone and explains to Dr G that she would like to go on the contraceptive pill as she is now in a sexual relationship with her boyfriend.

Dr G is understanding and listens to Amy, who appears to be making an informed decision. However, Dr G gently explains to Amy that as she is under 16, she cannot provide consent and will have to make another appointment and return with her mother. Amy becomes tearful and explains she won't be able to do that, as her mother does not know she is in a sexual relationship.

Dr G feels that Amy is competent to make an informed decision about using contraception. She is concerned that Amy may continue to have sexual intercourse with her boyfriend if she does not prescribe the pill, with the resultant risks of pregnancy and sexually transmitted infection. She calls MPS for advice.

Learning points:

- Young people over the age of 16 are treated as adults, are assumed to be competent and can give valid consent to treatment according to Section 23 of the Non-Fatal offences Against the Person Act (1997).
- Children under 16 are also often competent. However, there is no Irish law or court decision that holds that a child under 16 can give valid consent to medical treatment. Under the age of 16, the Constitution of Ireland recognises the "inalienable right and duty of parents" to provide for their children and to make decisions affecting their religious, moral, intellectual, physical and social welfare. The Medical Council states: "Where the patient is under the age of 16 years, it is usual that the parents will be asked to give consent to treatment on the patient's behalf."
- GPs are frequently consulted by unaccompanied under 16s seeking medical treatment. An attempt should be made to contact the parent, eg, by telephone, to gain consent. Consent may be implied by the parent making the appointment, but this still needs to be verified and documented.
- You should use your own judgment as to whether to see a minor who does not want their parents to know or be told about the consultation. There would be support for any GP who makes a decision to see a minor without parental consent if they believe the minor fulfilled Gillick principles – but any such decision must be documented carefully in the patient's notes.
- It is worth encouraging the patient to involve their parents in the decision making process and you could offer to assist with this.

Can I undertake a testamentary capacity assessment?

Mr M is an 82-year-old patient of Dr B. He is in the early stages of vascular dementia, but retains the ability to make certain decisions for himself. He is accompanied into the surgery by his daughter. Mr M explains that he would like to make a new will, but his solicitor has requested that a doctor makes an assessment of his mental capacity first. This is to ensure that the will is valid. Mr M provides Dr B with a letter, in which the solicitor asks for the GP to swear an Affidavit of Mental Capacity at the time of making the will. This relates to the patient's capacity in relation to the particular activity or action in question, rather than a general assessment of the patient's mental condition.

Dr B has undertaken mental capacity assessments before, but he is unsure how to proceed with the Affidavit. He calls MPS for advice to check he is within his area of competence before proceeding.

Learning points:

- Any doctor can assess testamentary capacity, not just a psychiatrist.
- Testamentary capacity is a legal test; it is not an exact science and can be very difficult to assess. It is a variable concept, which can be date and time specific.
- Even though the patient may not have capacity all the time, a will can be made in a lucid period if the person has capacity at the time it is made.
- Under Irish law, a person making the will or 'testator' must be 18 years or over or be married and must be of sound mind.
- The case of *Banks v Goodfellow* found that:
  - The testator must understand he is making a will
  - The testator must be capable of knowing the nature of his estate.
  - The testator must be able to give consideration to persons expected to benefit.
- Remember to bear in mind the individual needs of each patient – allow reasonable time for relaxed conversation between each test, speak in a clear manner which the patient understands, and assess capacity at a time of day which suits the patient.
- When assessing testamentary capacity, the Report of the British Medical Association and the England Law Society *Assessment of Mental Capacity – Guidance for Doctors and Lawyers* is a helpful guidance tool.

The canary in the coalmine

Dr Paul Heslin, a GP and occasional locum based in Dublin, looks at the misunderstood life of a GP locum

Being a GP locum has long been misunderstood and undervalued. The specialty of GP locum is the Cinderella of medicine. Once thought of as the poor ragged cousin of the medical family, locum work was seen as being suitable for doctors at the beginning and end of their careers. No proper doctor should see it as a real career path. It was ok for the young, inexperienced doctor before he got a real job for life; it was also ok for retired doctors after a life of experience, a sort of reward after a life of service, being put out to pasture. A "real" GP was totally committed to their 24/7/365 "calling", with personal continuity of care to "his" patients being a badge of honour.

But, as women began to colonise the vast continents of medicine, general practice made way for group practice, patients seeing different doctors, and sessional practice. The specialty of GP locums have being doing this for years: treating complex patients in brief, discontinuous interventions; sometimes picking up things the GP has missed; bringing a fresh perspective; fitting in and adapting to each practice. The emergent and modern, high-quality locum often brings new ideas from their travels among the many tribes and subcultures of general practice within Ireland and overseas.

And it is this wider experience from medical travel that makes locums an underused resource to practices that want to use their diverse font of knowledge. It is also one of the risks of being a locum. You see that things can be done differently in other places, and sometimes better, but the practice you are working in today might not fully appreciate the gift that you are offering them and may well bite back. No-one likes change, but for the lowly locum to come into a practice, and announce that they have seen things done better, or differently elsewhere, it can be taken as an insult.

It was a simple thing, a small thing, when I offered a Carlow practice (before computers became the rage), the idea that it might be better to write the constantly changing addresses of their patients in pencil rather than pen on the front page of their paper records so that five addresses were not overwritten in mad, unreadable scribbles. This Carlow GP practice took the new idea to heart and found great benefit from it. Other practices can be more wary of new ideas from the new kid on the block.

Specialist locums feel the added vulnerability of being a short-term locum. Like walking into a well-designed kitchen, where you just "know" where everything is, some well-organised practices "flow" and are easy to adapt to. Other practices are hard work – and have added risks for the transient doctor. Locums experience both the safe and unsafe practices in various GP practices. They have not yet become accustomed to the idiosyncrasies that each practice develops over time and which each practice comes to think of as normal. These local solutions can become real challenges for locums, or real bonuses and new ideas to be spread by bumble bee locums to other receptive and flowering GP practices. In this way, specialist locums can become the mediators of good practice and alternative practice, spreading the good news like travelling storytellers of Irish folklore. They can be the cross-fertilisation seeds of new possibilities to other GPs who do not have the same privilege of medical travel and diversity.

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Small things matter when you are a locum, like the much used computer keyboard with the letter "C" worn away and unreadable. The locum finds himself asking: "What is the letter to the right of "X"? It is "C". (By the way, the most used letter in the alphabet is "E".) The permanent GP is happy to work with the worn keyboard and has adapted over time, but the locum is completely put off by this added risk. And this can sometimes be just one of the cumulative risks that a locum has to adapt to, in swift time. This is the unique skill and talent of the professional locum.

If a GP needs to know a little about every specialty of medical practice, then a GP locum needs to know this as well as something about every type of general practice, with different computer software, different habits and different risks. But most of all, locums have to deal with the fact that many practices do not recognise the particular risks for locums as well as the unique expertise that they bring.

Like the canary in the coalmines, the locum can be an early warning sign of risk in your practice.

MPS General Practice Conference 2013

MPS

EDUCATION AND RISK MANAGEMENT

Spotlight on Risk

HOME

DATE: Thursday 12 September 2013

VENUE: Irish Management Institute (IMI), Dublin 16

TIME: Registration from 9.30am for a 10.00am start – 4.30pm close

COST: €60 for GP MPS members | €120 for GP Non-members | €40 for GP Trainees, Practice Managers, Nurses and Practice Staff

Our second annual conference for general practitioners and the primary care team – Spotlight on Risk – will put the focus on many of the top risks in practice and offer practical advice on how to manage them.

Today, more than ever before, it is vital for GPs and primary care teams not only to understand the medicolegal and ethical problems they face on a day-to-day basis, but also to be able to quickly and efficiently deal with them when they arise.

Topics covered include:

- General Practice – Risky Business: Top Risks including Medicine Management Protocols
- Patient Safety – The Patient Experience
- Claims Experience and how MPS Manages Claims
- Competence Assurance – How to get CPD
- Doctors in the Dock

Plus workshops on:

- Medicolegal Dilemmas
- Medical Records
- Mastering Adverse Outcomes
- Incident Reporting – Learning from Significant Events

CPD APPLIED FOR

For further information and to register:
www.medicalprotection.org/ireland/gp

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