MEDISEC ON CALL

Winter 2017

Around the clock support for the Irish GP community

MEDISEC ON CALL
winter issue 2017

Deirdre McCarthy, Senior Legal Counsel, is Editor of Medisec On Call. ***Should there be any topic you would like to see included in our newsletter, or if you no longer wish to receive it, you can email Deirdre at deirdremccarthy@medisec.ie***

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WELCOME TO OUR WINTER NEWSLETTER

Another year has flown by, our Hatch St office now feels like home, and it's Christmas! So much has happened in a year.

We were delighted with the success of our 'Best Practice' Conference held in Dublin in October. I would like to congratulate the conference team, speakers and members who worked so hard to produce such a useful learning opportunity. Our presenters were enlightening and entertaining, their topics entirely dedicated to the reduction of risk in General Practice. Ben Goldacre was a star performer - you can read all about him in the conference report in this issue.

Medisec have been pleased to welcome over 160 new members in the past year and we are honoured that they have entrusted us with their professional indemnity and medico legal advisory requirements. These GPs join a growing family of members to whom we are happy to provide 24 hour assistance and advice. No query is too small and I would like to encourage you to lift the phone to us if you have any concerns regarding one of the myriad of medico legal difficulties encountered in daily practice.

Another innovation this year for Medisec is the provision of our new online risk self-assessment audits. While providing an opportunity to examine and improve specific areas of risk in your practice, these can also assist you in meeting your obligations for your Medical Council CPD Audit requirement.

We have welcomed two new team members to the Medisec family this year. Aisling Malone solicitor, joined us in June and I know many of you will have already availed of and benefitted from her extensive experience in navigating the choppy waters of medico legal claims and complaints. Dee Duffy, solicitor, joined us at the end of November and I have no doubt that she will be another invaluable member of our advisory team.

Many of you will be aware that following recent legislation it is now mandatory in law for all doctors to carry professional indemnity insurance. Medisec have received confirmation from the State Claims Agency that your Medisec policy underwritten by Allianz plc satisfies these requirements in all aspects.

In other changes, the new 'Children First' guidelines are now operative, and this issue features a guide for you on the adjustments necessary in your daily practice.

As the 25th May 2018 looms many of you will be anticipating changes to practice procedures as the new General Data Protection Regulation (GDPR) comes into force, replacing the existing data protection framework under the EU Data Protection Directive. In this edition of 'On Call' we guide members through the real changes to your daily practice and help you devise new protocols accordingly.

All of the team here in Medisec are aware of the current challenges you are facing in General Practice in dealing with the increasing demands of the HSA and HIQA and fulfilling your CPD obligations. Clinically you are seeing increasingly complex patients with multiple co-morbidities and sophisticated medication regimes, holding packed flu vaccination clinics and dealing with the usual winter onslaught of viruses. If it happens, a medico legal issue, a Medical Council Complaint or a claim on top of all this might feel like the last straw. Please rest assured that Medisec will support and guide you through every step of the process.

Finally may I wish all our members and friends a very happy Christmas and the best of health and happiness for 2018.

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BENZODIAZEPINES:
TRIALS AND TRIBULATIONS

BY PROF. ANDREW W MURPHY
Professor of General Practice, NUI Galway, a GP in Turloughmore Medical Centre and Medisec GP Advisory Panel Member.

JOHN, 18 YEAR OLD STUDENT, 2ND UNIVERSITY YEAR

- Acutely upset; immediately tearful
- Unable to cope, not sleeping, anxious about:
  - 'getting things done'; 'keeping everything going'; 'a tablet to sort things'
- Paying own way through university as hotel porter
  - Worked full time all summer – rang in sick to get a week off
  - Working both nights at weekends
  - Very supportive family and girlfriend
  - Note for university and work; 'striking a balance' discussed; talk to parents and GFriend; Rx postponed
  - Review one week; much more settled; family will help with €

LEO HENRYK STERNBACH (1908-2000) HAS A LOT TO ANSWER FOR!

In an incredible life he lived first in Croatia and Poland, moving to Switzerland in 1940 to join Roche Pharmaceuticals (thereby just avoiding the Nazis) and then onto the US. He held over 241 patents, worked till he was 95 years and he almost single handedly transformed Roche. In an amazingly productive few years, he sequentially discovered chlordiazepoxide (Librium), diazepam (Valium), flurazepam (Dalmane), nitrazepam (Mogadon) and flunitrazepam (Rohypnol). Between 1969 and 1982, diazepam was the most prescribed drug in America, with over 2.3 billion doses sold in its peak year of 1978.

THE WORLD AS IT SHOULD BE

Forty years later the complexities of benzodiazepines are now much better understood. They are still indicated for a wide range of conditions (I have placed in bold those which are most frequent in general practice):

- Muscle spasm of varied aetiology; tetanus; anxiety; insomnia associated with **anxiety; severe acute anxiety; control of acute panic attacks, acute alcohol withdrawal; acute anxiety and agitation**; acute drug induced dystonic reactions; premedication; status epilepticus, febrile convulsions, convulsions due to poisoning; life threatening acute drug induced dystonic reactions; dyspnoea associated with anxiety in palliative care

However, the side effect profile is now much more apparent than in the halcyon (excuse the pun!) days of 1978 (see Box 1).

THE WORLD AS IT SHOULD BE: DIAZEPAM SIDE EFFECTS

COMMON (1-10%) OR VERY COMMON (>10%):
amnesia, dependence, drowsiness/ lightheadedness the next day, muscle weakness, paradoxical increase in aggression and especially in elderly: ataxia, confusion

UNCOMMON (0.001-1%):
libido change, dizziness, dysarthria, GIT, gynaecomastia, headache, hypotension, incontinence, salivation, slurred speech, tremor, urinary retention, vertigo, visual disturbances

RARE (0.0001-0.001%):
Apnoea, blood disorders, jaundice, respiratory depression, skin reactions and in children: headache, hypotension, urinary retention, vertigo

Significant side effects such as confusion in the elderly are very common. As a result best practice suggests that the use of benzodiazepines should be limited. For example, the following is a summary of NICE guidance for the management of generalised anxiety disorder:

- Full history (including alcohol and illicit drugs)
- Identify and treat any underlying conditions
- Offer referral to other first line low intensity services e.g. psychoeducational groups
- No improvement: offer choice of high intensity service (e.g. CBT) or drug treatment (sertraline then pregabalin)
- Do not offer a benzodiazepine to treat generalised anxiety disorder in primary or secondary care except as a short term measure during crises (my italics)

Unfortunately in Ireland, we often do not have ready access to such low or high intensity services and have to fall back on prescribing.

THE WORLD AS IT IS

In Irish general practice, benzodiazepines are still commonly used, especially for long term use. In one large study of the PCRS prescribing database, 5% of over 70's were prescribed long-acting benzodiazepines for more than a month, which accounted for 40% of all benzodiazepine prescribing for this age group (Cahir, 2010). Medisec members have been the subject of complaints to the Medical Council for 'benzodiazepine over prescribing' anonymously and by patient relatives, pharmacists and colleagues (In our own practice in Turloughmore, last year we prescribed 1,394 discrete prescriptions for benzodiazepines to 726 patients (there is a helpful patch on Socrates® which provides detailed information on such prescribing).

SO, WHAT TO DO? (GALLIA EST OMNIS DIVISA IN PARTES TRES)

Like Caesar's Gaul, benzodiazepines can be considered in three parts:

1. New presentations with acute self-limiting anxiety or insomnia
2. Long term 'therapeutic' benzodiazepine use and presumably dependent
3. People who use illicit drugs or high-dose users.

Box 2 outlines the presentation of John a typical patient with acute self-limiting anxiety.

An excellent general practice resource in this area is that by Ford & Law (2014) 'Guidance for the use and reduction of misuse of benzodiazepines and other hypnotics and anxiolytics in general practice' [https://smmgp.org.uk/media/11962/guidance025.pdf].

For such patients, they recommend the following, if prescribing a benzodiazepine:

- Apply NICE guidelines (!)
- Take a full history including alcohol and illicit drug use
- Ensure patient is aware of side effect profile and document this
- Consider delaying prescribing to subsequent visit
- Initiate lowest dose for 2-4 weeks max, with phased dispensing
- Advise regarding driving impairment and alcohol
- Taper off gradually when stopping
- Record all details of medication prescribed and duration

MONICA, 84 YEAR OLD WIDOW, VERY STRONG FAMILY SUPPORT

- Medical history
  - High blood pressure; CABG; Aortic Valve Replacement; AFib; CRF (eGFR 70ml/ min)
- Current medications
  - amlodipine; losartan/ HTZ; bisoprolol; atorvastatin; warfarin
- BZDP x >20 years

Box 3 describes Monica who is well known to us all – cheerful elderly multi-morbid patient, on a benzodiazepine for over twenty years and not clear to her or anyone else why she is on it. To compound matters, she is also on three hypotensive agents plus warfarin! When asked would she like to stop the benzodiazepine, she replies 'What ever for!?' Ford & Law (2014) are again helpful suggesting:

- Is this the right time to start a withdrawal program?
- Do they wish to stop? Has the original problem been resolved?
- Is there co-morbidity? Should withdrawal be managed elsewhere?
- Interventions:
  - Advisory letter
  - Minimal motivational intervention e.g. brief advice at consultation, self help book
  - More intensive intervention e.g. specific consultation, refer CBT
  - Gradual dose reduction
  - Move to diazepam reduction protocol
  - Gradual tapering over 3/12 to a year

The third group may be more complex - people who use illicit drugs or high-dose users. Many practitioners are very familiar with this group – others, not so and these patients may then be better managed by specialist abuse teams. Ford & Law (2014) suggest:

MANAGEMENT IS OFTEN COMPLEX

- Convert to the equivalent dose of diazepam
- Aim for the lowest dose of diazepam which controls symptoms of withdrawal 30 mg max/day
- Diazepam should be prescribed in 2mg and 5mg strengths only preferably as daily dispense and no more than one weeks supply at a time reducing diazepam dose by first trying 5–10% of the patient's usual daily dose every 2–3 weeks
- If a patient is struggling, hold the dose and reduction until the patient feels ready to continue
- Do not increase the dose.

CONCLUSION

Benzodiazepines are an exasperating combination of effectiveness and long term risks. There appears to be widespread divergence between guidelines and actual practice. Practitioners need to develop other strategies, apart from long term benzodiazepines, for the management of acute anxiety and insomnia. Practices may identify all patients on long term benzodiazepines and consider offering some a withdrawal program. For patients who use illicit drugs or are high benzodiazepine dose users, clear protocols are required.

GPS SHOULD BE AWARE OF THE NEW CATEGORISATION OF MOST BENZODIAZEPINES AND Z-DRUGS AS CONTROLLED DRUGS IN SCHEDULE 4 PART 1 OF THE MISUSE OF DRUGS REGULATIONS 2017 AND THE SPECIFIC CRITERIA TO BE INCLUDED ON A PRESCRIPTION FOR SUCH DRUGS.

GDPR

General Data Protection Regulation

GET IN GEAR

No doubt you will have heard much discussion about the General Data Protection Regulation ("**GDPR**") by now. It will come into immediate force in Irish law on **25 May 2018** and this has been well sign-posted and flagged for some time.

The GDPR imposes greater obligations on organisations which collect and process personal data and this includes GP practices of all sizes.

The GDPR has serious implications for you and your practice and you need to be fully up to speed with it. This article will give you an overview of what the GDRP is about and what it means for your practice. It will also set out a detailed road-map for your preparations, to get you on the way to compliance.

Preparing for the GDPR must be a key priority for your practice over the coming months. This is an opportunity for your practice to streamline procedures, with potential time and cost efficiencies. GDPR compliance will help you to safeguard personal data, build trust with your patients and staff and to protect your practice against complaints.

Background

The GDPR will replace the existing EU Data Protection framework and will standardise Data Protection rights for European citizens. The GDPR keeps and enhances many of the existing Data Protection principles. It puts great emphasis on transparency and security.

The GDPR will give individuals additional and stronger Data Protection rights. For example, it will be easier for individuals to bring private claims for compensation against data controllers for breach of data privacy.

How will the GDPR be enforced?

The GDPR gives Data Protection Authorities the power to sanction non-compliance. Sanctions can include fines of up to €20,000,000 or 4% of total global annual turnover.

A failure to report a breach could result in a sanction, in addition to a sanction for the actual breach. Financial sanctions are a serious consideration but the associated reputational damage for your practice could also be very damaging.

Get prepared!

You should inform your staff as soon as possible that the law is changing in relation to Data Protection and that it will mean changes in how your practice operates.

Someone in your practice must be responsible for Data Protection compliance, a designated Data Protection Officer ("DPO"). Many GP practices already have a designated DPO. Your practice DPO will be a key player in driving GDPR compliance within your practice. He/she will need the right knowledge, authority and support and may benefit from upskilling or specific training.

Preparing for the GPDR will be time and resource intensive. Your practice will need time to introduce changes required in a controlled manner. You should commence your preparations as soon as possible.

It is important to keep a paper trail of all steps taken towards GDPR compliance. We recommend starting with an education session for your staff on the GDPR and what it entails, followed by a paper-based exercise and meetings / workshops with your staff to work through the road-map set out below.

Where can I get more information?

The Office of the Data Protection Commissioner plans to issue a series of documents in advance of 25 May 2018. The first document, entitled "The GDPR and You" is now available at www.dataprotection.ie. More information and very helpful infographics are available at www.gdprcoalition.ie.

A detailed road map towards GPDR compliance:

It has been suggested that the main steps you need to take can be usefully grouped under the broad headings of: encryption and segregation of data, education, incident response planning and cyber insurance. The following suggestions will help you tackle each of these areas.

Appoint a Data Protection Officer

- This is mandatory for organisations which process sensitive personal data (e.g. health information) on a large scale which includes GP practices.
- Consider whether your DPO needs to be supported with training. If you already have a DPO, he/she may benefit from GDPR specific training or upskilling.

Consider whether you need a GDPR project team

- Preparing for the GDPR will be time and resource intensive. Depending on the size of your practice, the available resources in terms of staff and the competing demands on their time, you may need to set up a team or working group to lead GDPR compliance for you.
- If you are concerned about your ability to put resources behind GDPR preparation and compliance, you might consider prioritising the jobs that need to be done or getting external assistance and support.

Create an inventory

- You need to prepare a complete inventory of all the personal data that your practice holds. You need the input of all staff members to prepare the inventory. This will be your baseline information. For example, in respect of a patient, you might find that you hold the following data: personal details, contact details including next of kin contact details, date of birth, GMS number, details of previous GP (if any), payment history, medical history, clinical records, details of attendances / interactions, imaging, test results and correspondence.
- Bear in mind that the inventory will be a working document which will need to be updated. Make sure it is created in a user friendly format and that it is backed up.
- Start by asking your staff to complete a questionnaire with the details of the data they use in their day to day jobs.
- Ask your staff to highlight any high risk areas that they perceive and ask for their suggestions on how to mitigate those risks.
- Set a deadline for their responses and keep their completed questionnaires as part of the paper-trail.
- Hold a meeting to discuss their responses and to get a full understanding of the current position. Keep a note of what action points are identified and discussed.

Review the inventory

- For each piece of data, ask yourself:
  - How did you obtain it?
  - Why did you originally obtain it and what did you use it for?
  - Why are you holding it now?
  - How long will you retain it?
  - How secure is it?
  - If there was a breach of data privacy in relation to it, would there be a risk of harm to the individual concerned?
  - Do you ever share it with third parties and if so, on what basis?
- Keep a note of any concerns / issues / suggestions to work on.
- You may discover that there are records in your practice which should now be securely shredded / deleted. You will find a helpful guide to retention periods for records on medisec.ie.

How secure is the data you hold?

- You need to examine how securely you hold data. Does everyone in your practice have a unique log-on and password to the computer network? Passwords should be robust, routinely updated and they should not be shared.
- Consider the access authorisations that your support staff may have. Are they appropriate and necessary?

GDPR General Data Protection Regulation

GET IN GEAR

- Are you at risk of a breach of personal data for the want of a simple shredding protocol in your practice?
- Are your emails secure? Healthmail is a service available at no cost to GPs which allows healthcare providers to send and receive clinical patient information securely. Medisec recommends that its members should all use secure email.
- You may need to liaise with IT / software providers and have a security audit carried out to get a proper understanding of how robust your computer systems are and to learn about what improvements may be possible.
- Are your staff members aware of and trained about the risks of phishing/ scam emails and malware?
- What could you observe if you sat in your own waiting room with fresh eyes? For example:
  a. Do your receptionists inadvertently reveal personal data or clinical information when speaking with patients in person or by telephone?
  b. Are computer screens shielded from a patient's view at the reception desk?
  c. Are letters waiting to be scanned or prescriptions for collection left in clear sight?
  d. Can consultations in progress be overheard from the waiting room?

Establish the legal basis on which you collect and process data

- You need to consider the legal basis on which you hold and process personal data. GP practices largely obtain and process personal data with consent.
- Consent must be "freely given, specific, informed and unambiguous". Obtaining consent requires a positive indication of agreement. Consent cannot be inferred from silence or inactivity.
- You need to review how you obtain and record consent to ensure that it is appropriate and verifiable. A pro forma can be developed and designed to ensure your practice is GDPR compliant.
- If there is no paper trail, consider whether the consent actually complies with GDPR and if not, whether you need to seek consent again. For example, can you prove that you obtained consent to holding your patient's personal contact details?
- Don't forget to consider also the basis on which you collect your employees' data!
- There may be situations where you process personal data on a different legal basis e.g. statutory reporting requirements for infectious diseases etc. You must consider carefully what happens within your own practice.

Check what information is being shared with third parties and why

- In a GP setting, you may for example, share data with third parties when you send blood samples for analysis, when you write patient referrals to secondary care etc.
- As an employer, you may be sharing data with third parties if you have outsourced your payroll, HR function or accounts.
- Review the contracts you have with your third party service providers and make sure there are suitable confidentiality clauses and security obligations around protecting any shared data.
- Make sure that your patients / staff members are aware that their personal data may be shared in this way and that they have clearly consented to same.

Establish procedures to process requests

Your patients may want to exercise their Data Protection rights, which include: access, correction of inaccuracies, erasure of information, objections to direct marketing, restriction of processing and data portability.

- Some GP practices have procedures in place already for dealing with Data Protection requests and those procedures may only need to be tweaked. Other GP practices have been dealing with Data Protection requests on a more ad hoc basis. GDPR compliance will require standardised procedures to be in place.
- Your procedures will need to ensure that requests are processed within the new timelines i.e. within one month (currently the period allowed is 40 days, so you will have less time in future). If your practice frequently receives access requests, processing them in time could be a challenge.
- In most cases, you will not be able to charge for processing an access request. You may be able to charge a fee if processing the request will be administratively burdensome.
- Make sure your agreed process is workable and will meet your obligations. For example, you may need to look at IT solutions, like taking advice from external consultants or perhaps upgrading your systems. You should also assign specific responsibilities to specific staff members and have a contingency plan and written protocols in place in case a key member of staff is on leave etc.
- Your procedures should include a clear refusal policy and procedure. You have to be able to explain why a data protection request was legitimately refused e.g. why you might decline to rectify a record etc.
- A sample request handling process might look like:
  i. DPO logs the date of receipt of the request in a central Data Protection register.
  ii. DPO records the deadline for response and an advance reminder in a Data Protection diary which is reviewed weekly.
  iii. DPO acknowledges the request and confirms that a response will issue before the 30 day deadline.
  iv. DPO identifies and locates the relevant records.
  v. It may be appropriate for your DPO to make decisions on requests regarding restriction of processing and data portability. It may be more appropriate for the treating GP to make decisions on access / correction / deletion requests.
  vi. DPO implements decision made e.g. preparing copy records for release, arranging rectification / deletion and notifies requestor of decision within 30 day timeline. Medisec recommends that any records to be released are checked through beforehand by a medical member of the team.

Policy for dealing with a data breach

- Breaches must be notified to the Data Protection Commissioner within 72 hours unless the data was anonymised or encrypted so you will need to review the procedures you have in place to detect, report and investigate a personal data breach.
- Breaches which are likely to bring harm to an individual must be notified to the individuals concerned as well.
- Make sure your staff are aware of and compliant with these policies

Review your privacy notices

- Data subjects need to be fully informed about how you collect and use their data.
- Your practice's Data Privacy Notice will need to be updated. Currently, your Data Privacy Notice has to tell patients your identity, your reasons for gathering their data, the use to which it will be put, to whom it will be disclosed and if it will be transferred outside the EU. Under the GDPR, you will have to set out more information including the legal basis for processing the data, the applicable retention periods and details of the rights patients have under the GPDR, including the right to complain.
- Arrange to review your privacy notices at suitable intervals to make sure that your privacy notices are fully accurate and up to date.

Data Protection Impact Assessment ("DPIA")

Future projects will require a Data Protection Impact Assessment ("DPIA"). This means looking at any potential Data Protection issues associated with an intended project and finding a way to mitigate them. A GP practice might, for example, have to complete a DPIA as part of introducing new practice software.

Keep a paper trail

- You will need to demonstrate that Data Protection principles are complied with. It will be essential to embed a culture of awareness and compliance amongst staff. Your practice will need to keep records of processing activities going forward.
- Document all the steps you take towards GPDR compliance, from a note of your first planning meeting, to sign-in sheets at staff training and education sessions, to a paper trail of your consultation with your IT/ software providers, to an audit plan for ongoing monitoring and future compliance.
- It will help your practice move towards GDPR compliance to have the following templates:
  1. A website Privacy Statement;
  2. A practice Privacy and Confidentiality Policy.
  3. A patient leaflet regarding Data Protection;
  4. Consent form regarding the processing of personal data;
  5. Confidentiality agreements with staff members / confidentiality clauses in staff contracts / employee handbooks;
  6. Data processing contracts with third party service providers;
  7. Written procedures regarding the exercise of Data Protection rights including the policy on refusal;
  8. Written Personal Data Breach protocol; and
  9. Written complaints policy for the practice.

Remember that GDPR compliance is not a once-off project. Getting ready for its introduction will involve an initial wave of preparatory work but GPDR compliance must remain an ongoing priority for your practice thereafter. A full suite of sample policies is available at medisec.ie. Please note that any sample policy will require careful review and will need to be tailored to the particular workings of your practice.

Please also note that this article is intended to assist you with your preparations for GDPR compliance and is not intended to be an exhaustive summary of all steps required. If you are a Member and need further advice or have a specific query, please contact Medisec.

By Patrice O'Keffee, Partner, Comyn Kelleher Tobin, Medisec Panel Solicitors.

MINORS

THE COMPLICATIONS OF CONSENT

THE GENERAL DUTY TO OBTAIN CONSENT

It is the responsibility of the GP to ensure that appropriate and informed consent has been obtained before performing clinical examinations, investigations or treatment. Such consent must be voluntary, must be given by a person who has the capacity to give it and must be based on all information material to the treatment in question.

The situation becomes more difficult when a GP is dealing with a minor. The general rule of thumb is:

Under 16 years - parents or guardians of the patient should be asked to give consent to medical treatment on their behalf.

Age 16-18 years – minor can typically give consent to surgical, medical or dental treatment, but cannot give to consent to psychiatric treatment, organ or tissue donation or participation in medical research.

However, there are other considerations:

MEDICAL COUNCIL GUIDELINES, 8TH EDITION

When considering the general issue of consent by a minor, a GP should look at the Medical Council Guidelines. The relevant provisions are contained in Clause 18 and can be summarised as follows:

- It is the primary responsibility of the GP to act in the minor's best interests. The GP should try to involve the minor in discussions about their health.
- This GP should communicate in a way which is suited to the patient's age and intellectual capacity.
- The age at which a patient can legally consent depends on the type of medical treatment they seek.
- Patients over the age of 16 years may consent to surgical, medical or dental treatment.
- Patients under the age of 18 years cannot typically consent to psychiatric treatment, organ or tissue donation, or participation in medical research.
- GPs are advised that they should encourage young patients to involve their parents / guardians in the medical decision.
- If a patient who is under the age of consent, refuses to involve their parent or guardian, the GP should ask the following questions:
  - Is the minor mature enough to understand the relevant information and the consequences which may arise from the treatment?
  - Are the views of the minor stable and do they reflect their core beliefs?
  - Are there any physical or mental health issues which are affecting the minor's ability to make an informed, independent decision?
  - What is the nature of this treatment? i.e. Is it elective or essential? Does the treatment constitute a medical emergency? Clause 13.1 of the Medical Legal Guidelines allows for the provision of the medical treatment, in the absence of consent, in the case of an emergency.
  - Do the benefits of this treatment outweigh the risks involved?
  - If any welfare, protection or public health issues arise, are there protocols which must be followed?
- A GP may provide treatment to such patients if, having considered the above factors, they find that the patient has sufficient maturity and understanding to make the decision and it is in the best interest of the patient to do so.
- It is important that the GP seeks legal advice in a situation where a patient aged 16 or 17 refuses medical treatment, against medical advice and their parent's wishes.
- Parents / guardians should be asked to give consent on behalf of a patient who is under 16 years old. However, in the case of a patient who is under the care of the State, it may be necessary for the GP to obtain consent from the Child and Family Agency (CFA).

PATIENTS UNDER THE CARE OF THE STATE

If a patient is under the age of 16 (or under 18 years requesting psychiatric treatment, tissue or organ donation or to participate in medical research) and is in State Care, GPs must consider the following:

1. **Interim Care Orders or Emergency Care Orders – Section 13 and 17 of the Child Care Act 1991**
   These Orders are typically temporary in nature. Where a District Court judge makes an Interim Care Order or Emergency Care Order, he may give a direction to carry out a medical, psychiatric examination, treatment or assessment of a child.

   Tips
   - Where possible, a GP should insist upon receiving a copy of the Court Order / Direction
   - In cases of emergency, a GP must act in the best interest of the patient.

2. **Care Order - Section 18 of the Child Care Act 1991**
   If a minor is in Statutory Care, a GP should seek consent from an authorised person from the CFA.

   Under the legislation, a Care Order allows the CFA to exercise control over the minor as if it were his/her parent. The Act states that the CFA must always act with the aim of safeguarding and promoting the minor's health, development and welfare. Because of these duties, the CFA is authorised to give consent to any necessary medical or psychiatric examination, treatment or assessment with respect to the minor.

   It is critical that only an authorised person from the CFA can consent to such treatment and it is the duty of the GP to ensure that whoever is consenting on behalf of the minor is authorised to do so.

   Tips
   - Where possible, GP should insist upon receiving a copy of the Care Order.
   - GP should seek written consent from the authorised person within the CFA.
   - Consent does not last indefinitely and should be reconsidered at each presentation.
   - In cases of emergency, GP must act in the best interests of the patient.

3. **Voluntary Care - Section 4(3)(b) of the Child Care Act 1991**
   If a child is in need of care and protection, the CFA may take the minor into Care in the absence of an Order from the Court. If the minor is in voluntary care, the CFA does not have the authority to consent to medical treatment on the minor's behalf.

   The Child Care Act provides that while the minor is in voluntary care, the CFA must have regard to the wishes of a parent or any person that is acting in loco parentis of the minor in the provision of such care.Therefore, Social / Care Workers cannot consent to medical treatment on behalf of a minor in voluntary care in the absence of parental consent.

   Tips
   - GP should obtain parental / guardian consent in advance of treating the minor. This should be obtained directly from the parents / guardians or obtained via the child's social worker.
   - Consent does not last indefinitely and should be reconsidered at each presentation
   - In cases of emergency, GP must act in the best interests of the patient.

SUMMARY

In conclusion:

- Caution should be exercised when obtaining medical consent from a minor.
- GPs should always act in the best possible interests of the patient.
- Where a child is under the age of 16, as a general rule the GP should seek to obtain consent from the parents / guardians / CFA of the minor patient.
- If the minor refuses to involve their parents / guardians, it may be best to deal with each situation on a case to case basis. The GP should consider matters such as the child's maturity and their understanding of the decisions they are seeking to make, among other factors which have been discussed above.
- If a child is in the care of the State, it is the responsibility of the GP to ensure that appropriate statutory or parental consent has been obtained before providing medical treatment on behalf of the minor patient.
- In emergency situations, the doctrine of medical necessity applies. If a minor requires immediate lifesaving treatment and if there is no one available to consent, then a GP may administer the lifesaving treatment as appropriate.
- If in doubt, contact Medisec.

HUMAN FACTORS IN Complaints

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I vividly remember the first time that someone made a complaint about me. Speech and Language Therapists are usually liked by their clients and families and I felt this family had received the best of my care and attention, I was hurt, cross, embarrassed and upset in equal measure and was unsure what to do. I loved my work and I took great pride in delivering good care and this was devastating.
The mother of the child concerned was determined to report me to the Minister for Health and I had visions of being shamed before the houses of the Oireachtas.

I was lucky that my Director at the time was a very wise man-a doctor with significant experience in dealing with such matters. He seemed to understand the terror of his young employee and also the importance of hearing the concerns of a mother about her child. He gently took me down from my defensive platform. In a very caring way he listened and he heard. He saw the likely consequences of every action and inaction and he provided reassurance, guidance and a plan of action to ensure that everyone would be satisfied.

This experience, 40 years ago, has stood to me in my roles in later years which included the development of policies, procedures and guidance for the management of complaints in the Irish healthcare system. General Practitioners are the busiest healthcare professionals I know. They are the most accessible and the most visible to the community.
This makes it very difficult for them when an incident occurs or a complaint becomes public knowledge.

For more than 15 years I have been immersed in the hands on experience of hearing, managing, investigating and mediating complaints. I have observed the issues that cause people to make mistakes in healthcare and have witnessed the potential effects of complaints on those making them and those receiving them. Don't be afraid- acknowledge, admit and explain.

Doctors are often afraid of complaints from patients and their families. We ask patients to be partners in taking care of their health but sometimes when they question us, we don't like it. This can lead us to react defensively. Doctors often tell me that fear leads them to react in a way that makes the problem worse both for them and for the patient. Doctors should try to bear in mind that patients are not always right but they always have the right to be heard.

Trust yourself

Doctors need to trust that they have the skills and knowledge to deal effectively with any issue that might arise. In my experience doctors are better off when they acknowledge the imperfections of their service, their judgement, and even their demeanour on a particular day. Patients are very tolerant of human imperfection when it is acknowledged. The humility that comes with experience in any field and is a very reassuring and attractive quality and is especially so in a doctor.

Say sorry!

My advice is that if you realise that something has gone wrong or that your attitude to the patient was not how you would wish-don't wait for the complaint-lift the phone and acknowledge the distress caused, admit if something was below standard and explain what you intend to do to ensure that where possible no other patient will have the same experience.

Open Disclosure has been National policy since 2013 and has been embraced by most hospitals-tell the patient when you've got it wrong.

An apology is not an admission of liability.

It has taken us years to shake off the now out-of-date advice 'whatever you do don't apologise'. All most people want is an apology. Many people are driven into an adversarial process because their pain and suffering is not acknowledged and nobody has said they were sorry.
I have never seen any doctor at a disadvantage because he/she apologised-quite the opposite. Following our own instincts and taking the course of action that we would wish for our sister, our husband or mother is likely to be the right response for the patient.

An open culture

Patients can sense if a GP practice exudes openness.
The first person the patient meets is most important in setting the tone. The receptionist who takes the extra second to look at the patient shows them that they matter. Signage telling patients that the doctor wants to know how they experience their care suggests a competent, confident and caring practice. If the patient can't tell the practice that there is a problem they will tell lots of other people and possibly the Medical Council, the HSE or even Joe Duffy.

Complaints don't go away just because you want them to. Ignoring a complaint or not admitting to an error will not help matters. Encouraging staff to tip you off if someone seems upset or annoyed makes a difference. It is difficult in a busy practice but it has been shown to be cost effective to set time aside once a week for responding to these unexpected events.

The Medisec Comments, Suggestions and Complaints policy and procedures is the perfect start. Make sure that all staff are aware that your practice wants to hear from patients and their families and that you welcome comments and complaints. Patients need to know that the culture of your practice is to welcome feedback.

People respond to complaints in a variety of ways. The wise doctor will meet with the patient and or the family, show compassion, acknowledge, explain and apologise for the incident if appropriate. If the doctor has done his/her best to resolve the complaint and the patient/family is still unhappy the doctor should not be embarrassed to seek help. It can be useful to ask another doctor for help and support or to involve someone who will be independent in resolving the issues with and for you.

More complex complaints may require a full investigation to get to the root cause of the problem which may relate to systems. Following investigation it may be helpful to use mediation to assist in reinstating a healthy doctor-patient relationship and thereby the reputation of the practice.

Identify your top risks, assign responsibility and fix what you can

If you spot it sort it- can't sort it - report it

General Practitioners deliver care in an environment which is fraught with risk. Doctors are humans and medicine is an inexact science. Identifying and managing the risks in what you do is the key to minimising the likelihood of causing serious harm.

Consider if there is anything in your environment that is likely to cause harm to a patient or prompt a complaint. Have a look at the reception area and the demeanour of your staff. Are they under such pressure that they are unable to smile and have a word with the patients coming in? Could time consuming processes be simplified? It is so important to foster a culture where staff are given responsibility to identify and assess all risks, manage the risks and audit compliance. Risk will never be eliminated but being aware of the issues most likely to cause harm or cause a complaint is great start.

Teamworking

Just because you work in the same building every day and meet in the corridors doesn't mean you communicate well as a team. Protect time for a formal meeting at least every week. Have complaints on the agenda so that you don't miss anything.

Short formal meetings with the team ensure sharing of important information.

Communication

One of the key non-technical skills in clinical practice is communication. Adequate communication is fundamental to effective clinical practice. Active listening, positive body language, appropriate volume, tone, inflection and emphasis make a difference to the clinical experience for the patient.

A very informative Medical Council project "Listening to Complaints Learning for Good Professional Practice" examined complaints handled by the Medical Council in the period 2008-2012. Almost 2000 complaints were included in the quantitative review and 100 complaints files were selected for deeper analysis through the qualitative review.

Key themes that emerged included the importance of acknowledging and managing different components of competency of medical practitioners. The traditional distinction between 'hard' and soft competencies e.g. clinical knowledge and skills on the one hand and interpersonal skills on the other is an invalid distinction from the perspective of patients. The public expect that doctors will not only be clinically proficient but they will also have and demonstrate good listening skills, compassion and other interpersonal skills.

I advise doctors that time spent dealing with a complaint at the very beginning in an open and honest manner saves time, money, and a great deal of distress later.

Seek support and advice if neccesary and always share learnings from a complaint with your team to enhance your service going forward.

MEDICAL RECORD AMENDMENT REQUESTS

by Antonia Melvin,
O'Connor Solicitors,
Medisec Panel Solicitors

Under the Data Protection Acts there is an obligation on data controllers to ensure the personal information they keep is accurate and up to date. (A Data Controller is the individual who controls and is responsible for the keeping and use of personal information, so in most practices this will be the General Practitioner/Partners.) As a corollary to this, under section 6 of the Data Protection Acts 1998 -2003, an individual has a right to seek to have information held about them rectified or in some cases erased if the information held about them is factually inaccurate, out of date or collected unfairly.

This right to rectification, however, is not an unqualified right, it depends on the circumstances of each case and can be complicated when it relates to medical records. Given the importance of the integrity of contemporaneous medical records, alternation and or amendment of such records is subject to regulation.

Where a request is received from a patient to rectify a straight forward and accepted inaccuracy in a medical record such as an error arising out of an administrative error or spelling of a name, the request should be granted while adhering to the usual recommendations for corrections or alterations to medical records:

HSE Standards and Recommended Practices for Healthcare Records Management V3 P25:

"3.3.11 Deletions or alterations are made by scoring out with a single line followed by:

a. signature [of the person making the change] (plus name in capitals) and counter-signature, if appropriate.
b. date and time of correct entry.
c. reason for amendment.

3.3.12 Corrections are made as close to the original recording as possible."

However, where personal information is of a subjective nature, the right to rectification is not always appropriate. Difficulty can arise where the GP disagrees with the patient in relation to the accuracy of the information complained of and/or where the amendment requested would, in the belief of the GP compromise the integrity of the contemporaneous medical records.

In such situations, The Data Protection Commissioner has suggested that a possible approach, in the interests of achieving an amicable resolution, is for the Data Controller, i.e. the GP, to add an annotation to the record to the effect that the data subject believes that the data is inaccurate for reasons which are then indicated. In this way the annotation can supplement the medical record to satisfy the patient without materially changing the record. Any such annotation must include the requirements listed in the HSE standards quoted above.

CHANGE OF NAME REQUESTS:

General Practitioners may receive requests from patients seeking to change their own name on their medical records or from parents/guardians requesting a change to the name of a child.

Firstly in relation to requests regarding adults,

a) Patients should make such requests in writing.
b) Where possible, they should provide legal evidence of the name change e.g. marriage/civil partnership certificate, birth certificate, deed pole certificate, PSC card.
c) Photo identification may also be required in some cases.
d) The written request and a copy of any supporting document should be placed on the patient file and the records and IT Systems should be updated.
e) The front sheet or cover of paper files should be replaced with the new name and the IT System updated.
f) From a continuity of care point of view there should be a record of the change of name made within the patient notes and a record of the previous name must be kept on the IT system with the new name being used going forward.

CHILDREN:

The name of a child should only be changed at the request of a parent/legal guardian[1] or, in the case of adoption situations a Child Care Agency:

a) Such requests must be made in writing.
b) Appropriate legal evidence of the name change should be provided e.g. Birth certificates, passports, deed pole certificates, PSC cards or in cases relevant to adoption, adoption certificates.
c) Where there is a dispute between guardians as to a change of name or the appropriate name to be used in relation to a child, the name evidenced in the legal documentation referred to above must be used.
d) In relation to a name change as a result of adoption, the name change should be considered at the time of placement with the adoptive parents; on receipt of a letter from the placing adoption agency confirming the placement and that the adoption application is being processed. Adoptive parents should submit a copy of the amended adoption certificate when the adoption is finalised.
e) In certain adoption cases, such as closed adoptions, additional requirements may be necessary and specific advice should be sought.
f) The written request for name change and a copy of any supporting document should be placed on the patient file, a note of any relevant conversations with guardians should be made in the notes and the records and IT Systems should be updated.
g) From a continuity of care point of view there should be a record of the change of name made within the patient notes and a record of the previous name should be kept on the IT system with the new name being used going forward.

CHANGE OF GENDER REQUESTS

Requests can also be received from individuals who have or are in the process of transitioning from their gender of birth to their preferred gender, to have their preferred gender reflected in their medical records.

In such circumstances GPs should advise the adult patient to apply for a Gender Recognition Certificate. The Gender Recognition Certificate allows a person to self-declare their gender, without any medical intervention or a report from a GP.

The Gender Recognition Act 2015, which came into effect on the 8th September 2015, provides that a person over the age of 18 can apply for a Gender Recognition Certificate to the Department of Social Protection in order to have their preferred gender recognised by the State. The Application Form can be found here **http://www.welfare.ie/en/pdf/GRC1.pdf**

Young people aged 16 and 17 years can also apply to have their gender recognised, though the process is more onerous and an application to the Circuit Court is required. Once a Gender Recognition Certificate has been issued by the Department of Social Protection, a person may apply in writing to the General Register Office asking that information relating to the recognition of their gender be entered in the Register of Gender Recognition.

A GP should request that the patient furnish a request in writing and provide a copy of the Gender Recognition Certificate or a copy of their entry in the Register of Gender Recognition which should be kept on file. The patient's gender and, if applicable, name, should then be amended on the patient's records and IT systems, should be updated but as above a record of the previous name should be kept.

A further necessity arising out of a gender request change is that the change of gender must be flagged in the designated space for recording alerts in the healthcare record. This is important to ensure that, going forward, the appropriate male or female specific diagnostic and screening issues that may still arise or apply as a result of the birth gender (notwithstanding the gender change), are appropriately considered and are not overlooked or missed.

The fact of and purpose of this alert system must be fully explained to the patient. It should be recommended to the patient that they discuss these screening issues with their gender reassignment team regarding what protocols may be put in place going forward to address them and that you, as their GP, be notified as required for relevant follow up. This discussion with the patient should be recorded in the patient notes.

The purpose of this article is to highlight some of the matters to be considered when dealing with such requests, however, in many cases relating to gender change requests, further issues may arise and it may be necessary to seek specific advice from Medisec.

[1]While children between the ages of 14 and 17 can apply to change their name by deed poll the consent of both parents is required.

BEST PRACTICE CONFERENCE 2017


Dr Myra Cullinane


Prof Andrew Murphy


Dr Mary Davin-Power, Deirdre McCarthy, Aisling Malone, Suzanne Browne, Ruth Shipsey and Jim Glennon

Dr Ben Goldacre


Dr Conor O'Shea


Prof Walter Cullen


Dr Ronan Boland


Fintan Foy


Eileen Barrington S.C.

From early morning on the 14th of October there was a frenzy of activity in the Conrad Hotel Dublin as preparations for the Medisec Best Practice Conference were in operation. Delegates started to trickle in just as the Barista cart was beginning to brew up and the aroma of freshly ground coffee began to waft out towards the National Concert Hall where some members have fond memories of their college days in the UCD Medical School. No freshly ground Barista coffee back then!

There was a warm welcome from the Medisec team awaiting members and friends who were greeted on arrival. Before long there was a hubbub of chatter as delegates met old pals and colleagues. Attendees quickly divided into the healthy brigade, making straight for the fruit skewers, and the traditionalists who lingered around the pastry plates hoping for a second hit.

No time for second helpings as **CEO Ruth Shipsey** opened the meeting under the watchful eye of Chairman of the Board **Jim Glennon**, welcoming all and remembering the origins of Medisec with a small presentation for many of the founding members who were in attendance.

First speaker to the podium was **Professor Andrew Murphy** warning us about the Trials and Tribulations of benzodiazepine prescribing, the practicalities and difficulties, and the need to adhere to current guidelines. He discussed counselling the patient, discussing alcohol and driving, and suggested delaying prescribing. He emphasised the importance of recording all plans and prescriptions, as well as exploring other aspects of anxiety management. A telling video was shown illustrating how street drug users knew how they could obtain prescriptions easily without question from some medical professionals.

Prof. Murphy was followed by **Eileen Barrington S.C.** who spoke about the mechanics of a Medical Council Complaint from preparation for Preliminary Proceedings to appearing at a Fitness to Practise Inquiry and the possible sanctions imposed. A difficult subject for any GP to listen to, and all were grateful for the advice given.

Dublin City Coroner **Dr Myra Cullinane** was next to the podium to clarify the relationship between the GP and the Coroner's office, from preparing a Coroner's Report to preparing for appearance at an Inquest. The Coroner gave down to earth practical advice and illustrated how the Coroner is generally happy to engage with the GP should any queries arise regarding the death of a patient. 'If in doubt, call the Coroner' was the abiding message.

Guest speaker, academic, scientist and campaigner **Dr Ben Goldacre** leapt to the stage after his Medisec Barista double espresso (now we know how he does it) and launched into the forensics of how scientific research studies can be falsified and misrepresented by the study originators and by the media reporting them.

Outcome switching and composite outcomes can sway the reality and misrepresent the science therein. When reading a comparative study pay attention to the dosages of the new versus old drugs - low doses of new drugs are much less likely to cause the side effect that the high dose of the old drug might cause! An interesting slide was the PHd Certificate of qualification earned by his dead cat, Hettie, illustrating how easy it can be to obtain qualifications!

After a delicious and social lunch, **Professor Walter Cullen** addressed 'Dropping the Ball' between primary and secondary care. He referred in depth to a Medisec 2016 study investigating risk in the interface between the two , and emphasised the learning points. 14% of Medisec claims were due to difficulties in communication between primary and secondary care. The main issues concerned referrals, discharges, GP follow up and medication reconciliation. If in doubt – Check, Consider and Call.

Four sessions of 'Ten Top Tips' provided a useful finale to the day.

Dr Ronan Boland, General Practitioner and Expert Witness in his 'Write There Right Now!' session reflected the difficulties he sees when writing reports, and emphasised the importance of keeping good records, illustrating the difficulties in defending a doctor when the records are poor or absent. He reminded us of recording outside the surgery setting, particularly house calls and telephone calls.

Dr Conor O' Shea GP and National Coordinator HSE/ICGP GPIT Group, gave a sobering account of how easy it is to be invaded by kidnappers who take over your patients and charge enormous amounts of money for you to retrieve them – virtually that is. Ransomware is now a fact of life and he kept us hanging on a thread as he built the suspense around what happened as his finger hovered over a dodgy email attachment! Even Conor can be caught unawares so be careful out there.

His top tips were: don't open it, pay a professional to guard your software, back up your data, think before you click and have unique log ins for all staff, along with many more pearls of wisdom.

Senior Medisec Legal Counsel **Deirdre McCarthy** gave her top tips on handling complaints in the practice, and emphasised the importance of open disclosure and having a complaints policy. Don't ignore the complaint and address it promptly. Have a protocol for complaints handling and stick to it. Take all complaints seriously and investigate. Ensure all staff know and follow the protocol.

Senior Clinical Risk Advisor **Mary Davin-Power** gave her top ten hazards in prescribing and her top ten medications to watch. Transcribing between primary and secondary care scored high in the risk register, as did the lack of a repeat prescribing protocol, paediatric doses, polypharmacy and toxic medications. The top ten troublesome drugs included NSAIDs (renal damage, cardiac risk) NOACs, (repeat prescribing) Benzodiazepines (overprescribing) and Iron injections (skin staining). Monitor toxic medications and consider auditing your repeat prescribing. Consider auditing even one troublesome drug using the practice software system.

The final speaker of the day ICGP CEO **Fintan Foy** described how the College are aware of the problems today in general practice and have come up with solutions, but getting the message across and being listened to was a difficulty in today's climate. He illustrated how the college is addressing the problems of recruiting and retaining younger GPs. He also had some top tips – Change is opportunity- Be leaders not victims - and that the College aspires be a home for diversity and unity of purpose and intention in General Practice.

The winner of the competition for a risk reduction suggestion was **Rukshan Goonewardena**, who was presented with a framed set of Medisec Practice Posters by Ruth Shipsey. His winning suggestion was that Medisec introduce a waiting room poster reminding patients of the importance of regular medication reviews.

Jim Glennon had kept the audience updated on the Leinster match throughout and following a bonus point win against Montpellier, it was on a relaxed and confident note that he brought the proceedings to a close.

COMMENCEMENT OF THE CHILDREN FIRST ACT 2015 AND INTRODUCTION OF NEW CHILDREN FIRST:

NATIONAL GUIDANCE FOR THE PROTECTION AND WELFARE OF CHILDREN

The revised Children First: National Guidance for the Protection and Welfare of Children were launched in early October 2017. It is essential for all GPs to be cognisant of their obligations under this Guidance, which supersedes earlier versions published in 1999 and 2011.

The updated Guidance was published to take into account requirements under the Children First Act 2015. Until now, only some of the provisions of that Act have been in force. However, the Act will be fully commenced on 11 December 2017 and specific child protection obligations will be imposed on Mandated Persons from that date forward. The Children First Act 2015 will operate side-by-side with the non-statutory best practice which is outlined in the Guidance.

This article is merely an overview and is not intended to be a substitute for GPs reading the Guidance in detail. Tusla has devised an e-learning training module which is available at www.tusla.ie. We know that GPs will have many questions and maybe some concerns regarding these new Guidelines. We obviously encourage any Medisec members with questions to contact us for advice and assistance at any stage.

Mandated Persons have contact with children and/or families and because of their qualifications, training and/or employment role, are in a key position to help protect children from harm.

GPs are Mandated Persons and as a result, have two key obligations under the Children First Act 2015 and Guidance:

I. **To report the harm of children above a defined threshold to Tusla; and**
II. **To assist Tusla, if requested, in assessing a concern which has been the subject of a mandated report.**

1. MANDATORY REPORTING

Harm is defined as assault, ill-treatment, neglect or sexual abuse. The Guidance describes each category of harm in detail in Chapter 2 and it also details how to assess the threshold for harm at which a mandatory reporting requirement will be triggered.

If you have reasonable grounds to believe that a child's health, development or welfare have been or are being seriously affected, or are likely to be seriously affected, the threshold for mandatory reporting is met.

(If you have doubts as to whether your concerns meet the threshold, contact Tusla to discuss your concerns and to seek guidance.)

If you have a concern about a child, you need to assess whether it meets the threshold for a mandated report or not. If you are satisfied that the threshold is met, you need to report the matter and mark your report clearly as 'a mandated report'. The form template is available at www.tusla.ie and it is important for you to use the prescribed form.

Include as much information as possible to assist the social workers, such as:

- The child's name, age, address and school
- Names and addresses of parents/guardians
- Identity of the alleged perpetrator
- An account of your grounds for concern
- Whether there are other children potentially at risk e.g siblings in the household and their names
- Your name, contact details and relationship to the child.
  (Note: Mandated Persons cannot make anonymous reports and attempting to do so may put you in default of your legal obligations.)

Reports should be made to the local social work duty service in the area where the child lives. Contact details for the Tusla social work teams are available on www.tusla.ie.

You are not required to inform a family that you are making a report but it is best practice to do so (to include explaining your reasons) unless informing the family may:

- place the child at further risk; or
- impair Tusla's ability to investigate the concern and carry out a risk assessment.

Details on Tusla's role and how reports of concern will be dealt with are set out in Chapter 5 of the Guidance.

Enforcement of the Children First Act 2015 and Guidelines reporting obligations

The Children First Act 2015 does not impose criminal sanctions on persons who fail to make a report to Tusla. However, there may be potential consequences if, after an investigation, it emerges that you did not make a mandated report and a child was subsequently left at risk or harmed. It is open to Tusla to make a complaint about you to the Medical Council and / or to report you to the National Vetting Bureau of An Garda Síochána.

Protection for mandated persons making a report

The Protections for Persons Reporting Child Abuse Act 1998 will protect you if you make a report of suspected child abuse to designated officers in Tusla, the HSE or An Garda Síochána and it proves to be unfounded. This protection only applies to reports made reasonably and in good faith. The defence of qualified privilege[1] may also be available in certain circumstances.

2. MANDATORY ASSISTANCE

In some instances, Tusla may need more information from the person who reported a concern or where someone else has reported they may come to the GP to seek information. The more detailed your initial report, the less likely you are to be contacted for supplemental information. It would be usual practice for you to continue to engage with the Tusla social work team as necessary to assist in protecting the child. You may be asked to provide any necessary and proportionate assistance to Tusla.

You must comply with a request for assistance from Tusla, regardless of whether you made the initial report which led to Tusla's involvement or not. Mandated assistance might consist of giving information verbally or in writing, preparing a report or attending a meeting.

Data Protection legislation does not prevent you sharing information on a reasonable and proportionate basis with Tusla for the purpose of child protection. Under section 16(3) of the Children First Act 2015, you are also protected from civil liability for sharing information with Tusla at its request.

Tusla is also permitted to share proportionate information with you, as necessary. You cannot share any information obtained from Tusla in this way, with any third parties.

If you feel you need to share information obtained this way with a third party, you must contact Tusla first and obtain written authorisation to proceed.

[1] As a general principle, qualified privilege may attach to communications where the sender has a legal, moral or social duty to impart the information and the recipient has a duty to receive it.

EXEMPTIONS FROM REQUIREMENT TO REPORT

a) Consensual underage sexual activity

If you have reasonable grounds to suspect that a child has been, is being, or is at risk of being sexually abused, then you must report this to Tulsa under the Children First Act 2015. Sexual abuse to be reported is set out in Schedule 3 of the Children First Act 2015.

Chapter 3 sets out an exemption from the requirement to report in relation to certain underage consensual sexual activity between teenagers. The Guidelines provide that

"If you are satisfied that all of the following criteria are met, you are not required to make a report to Tusla:

- *The young person(s) concerned are between 15 and 17 years old;*
- *The age difference between them is not more than 24 months;*
- *There is no material difference in their maturity or capacity to consent;*
- *The relationship between the people engaged in the sexual activity does not involve intimidation or exploitation of either person*
- *The young person concerned states clearly that they do not want any information about the activity to be disclosed to Tusla*

In effect, this means that it all of the above conditions are met, you as a mandated person do not have to report consensual sexual activity between older teenagers as sexual abuse to Tusla"

These criteria are also set out under Section 14(3) of the Children First Act 2015 and will become statutory requirements on 11 December 2017.

The Guidelines seem to move away from the idea of Gillick competence and the assessment of 'mature minors', which has been favoured in the UK and with which

Irish GPs may be familiar, but which was never tested in the Irish Courts.

In Medisec's view, the Guidelines leave no scope for ambiguity regarding sexual activity involving under 15's. This must be reported to Tusla. This is the logical consequence of the detailed exemption which is clearly limited to minors falling within the 15-17 age bracket.

In trying to determine whether the 15-17 exemption on reporting applies, you should take into account and record information regarding:

- the young person's behaviour, maturity and understanding as well as their family, home and living circumstances
- differences in age, maturity or power between sexual partners
- any apparent emotional or psychological pressure to keep the relationship a secret
- the use of drugs or alcohol which might influence the young person
- any other factors which might render the young person vulnerable.

You need to ask probing questions and if you are doubtful about the information obtained and you are not sure all the criteria are met, you are required to make a report to Tusla. You should always act in your patients best interests and provide appropriate clinical treatment.

b) Information obtained outside professional duties

Your legal obligation to report under the Act applies only to information acquired in the course of your professional work or employment. It does not apply to information obtained elsewhere or through a personal rather than professional relationship.

Although the legal obligation to report only arises to information obtained through professional duties, you should comply with the Guidance and report all reasonable concerns to Tusla.

You will already be aware that other legislative provisions may be relevant and you should continue to bear the following in mind:

i. **Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012**
It is a criminal offence for any person who has information about a serious offence against a child, which may result in charges or prosecution, to fail to report this to An Garda Síochána.

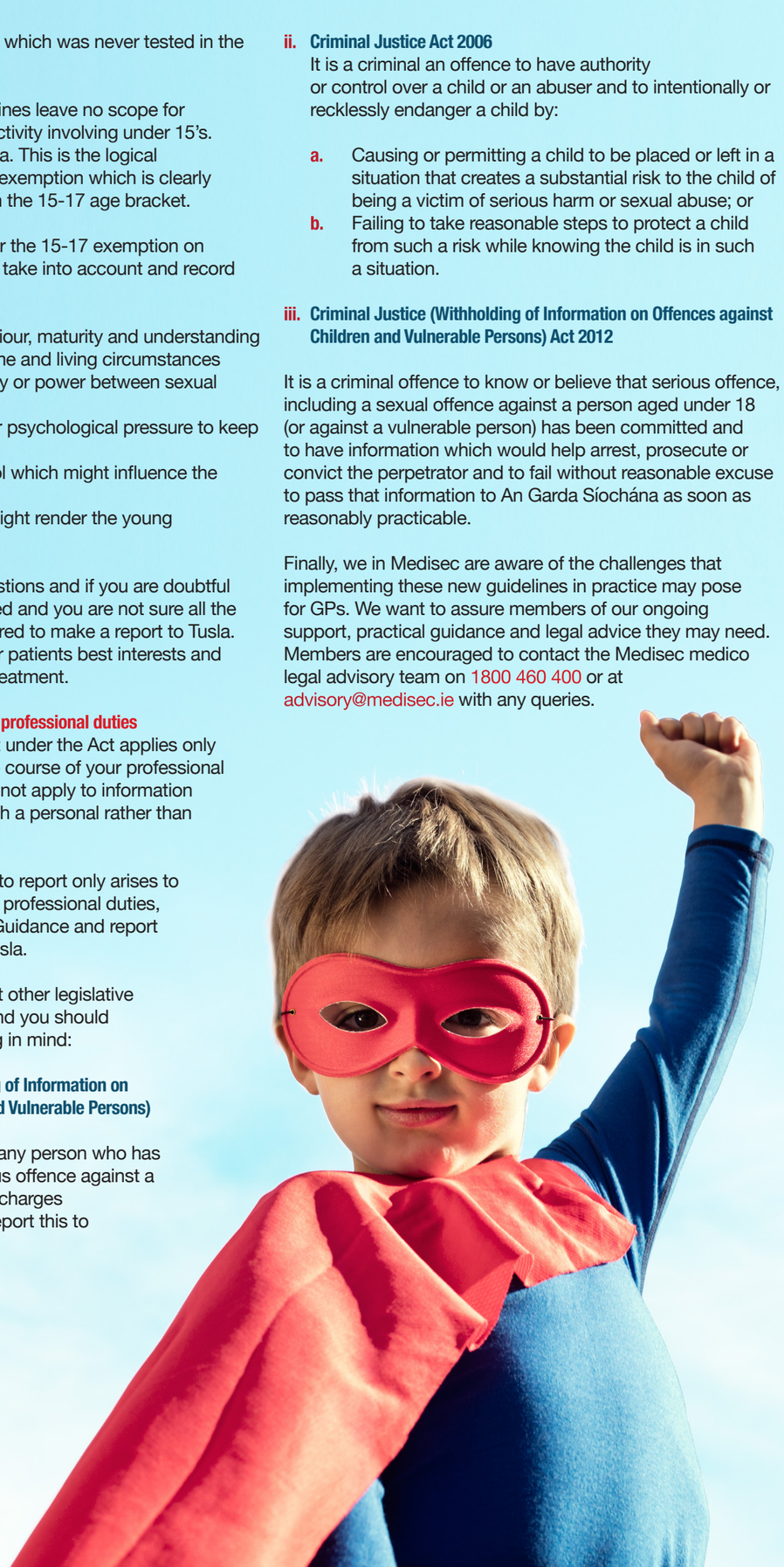
ii. **Criminal Justice Act 2006**
It is a criminal an offence to have authority or control over a child or an abuser and to intentionally or recklessly endanger a child by:

a. Causing or permitting a child to be placed or left in a situation that creates a substantial risk to the child of being a victim of serious harm or sexual abuse; or
b. Failing to take reasonable steps to protect a child from such a risk while knowing the child is in such a situation.

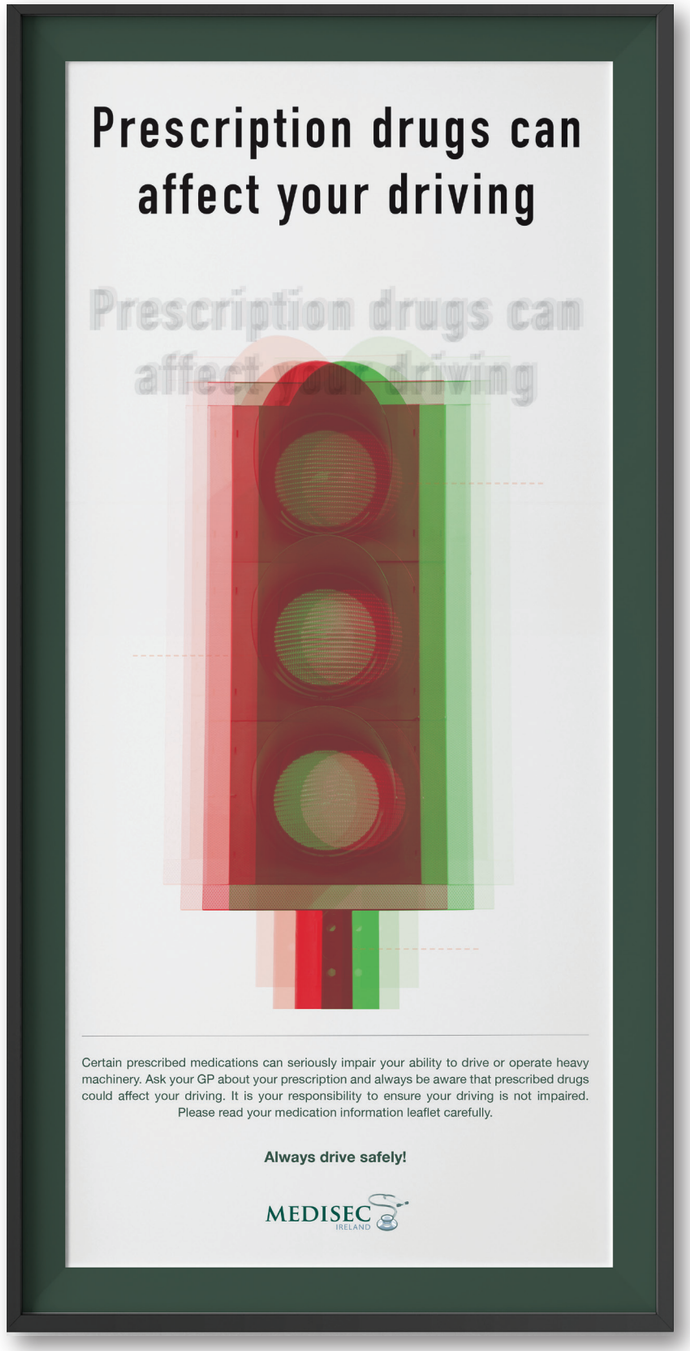
iii. **Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012**

It is a criminal offence to know or believe that serious offence, including a sexual offence against a person aged under 18 (or against a vulnerable person) has been committed and to have information which would help arrest, prosecute or convict the perpetrator and to fail without reasonable excuse to pass that information to An Garda Síochána as soon as reasonably practicable.

Finally, we in Medisec are aware of the challenges that implementing these new guidelines in practice may pose for GPs. We want to assure members of our ongoing support, practical guidance and legal advice they may need. Members are encouraged to contact the Medisec medico legal advisory team on 1800 460 400 or at advisory@medisec.ie with any queries.



MEDICINES & DRIVING



Driving under the influence of drugs has been an offence in Ireland since 1961. According to the law, a person's driving must not be impaired from alcohol or drugs.

Driving under the influence of drugs puts driver, passengers, cyclists and pedestrians all at risk. It is important to remember that even small amounts of certain drugs can affect a driver's skill and judgment on the roads. Many prescribed and over the counter medications can affect and impair someone's driving. Since April 2017, new legislation states that a person cannot drive while over certain limits of 3 specified drugs, Cannabis, Cocaine and Heroin, regardless of whether their driving is considered to be impaired or not.

It is also an offence to drive if one's driving is impaired by benzodiazepines or opiates, although to have a positive test for these drugs does not in itself lead to prosecution if one's driving is not impaired.

Roadside salivary testing for drugs is now in operation which tests for the presence of benzodiazepines, opiates, heroin, cannabis and cocaine.

Patients may request an exemption certificate from their GP if they are taking some of these substances as prescribed medications. The only situation where a doctor's exemption certificate is required is for patients taking medicinal cannabinoids. This will provide exemption from prosecution if the patient's salivary test is found to be above the designated limits for cannabis, but will afford no protection if their driving is impaired.

Where a patient is taking other opiates, for instance codeine containing medications such as 'Solpadeine', 'Solpadol' etc or if they are on benzodiazepine medications, a letter of exemption is not required, but they will be subject to prosecution if their driving is found to be impaired.

Many other medications can impair a person's ability to drive such as some antihistamines, some anti-depressants, some anti-epileptic medications etc. Often these effects are potentiated if even moderate amounts of alcohol are consumed.

Medisec recommend that patients are warned about the potential effects of medication prescribed or recommended by the GP. Advice of this nature provided to patients should be carefully recorded.

This poster has been designed for your waiting room to alert patients of the dangers of drug driving.

TO ORDER A FREE POSTER FOR YOUR SURGERY OR A MEDISEC PATIENT INFORMATION LEAFLET PLEASE EMAIL INFO@MEDISEC.IE OR CALL US ON 01 6610504

DR THOMAS LYNCH EXPLAINS HIS APP FOR CAPTURING CLINICAL IMAGES.

GPs write clinical notes to describe a clinical problem, to help record accurately how the patient presented and what their concerns were. It is the workhorse of GP practice and helps GPs make accurate clinical decisions at the time or later as they step back and reflect on them.

A clinical image is another tool GPs can use to improve the overall clinical note. It often complements a written clinical note. GPs may even improve it in some circumstances.

There are many potential areas throughout general practice where photography can be used. One can accurately record a picture of a rash, a skin lesion, a wound and many more. This is the beauty of clinical photography, it elucidates sometimes difficult to describe skin problems.

It can also facilitate the follow up of patients and aid decision making. For example, a picture of a patient with acne on their initial presentation which is recorded in their clinical note, can be easily compared to their current presentation. This is especially helpful if you were not the initial treating physician.

It can also be useful to help monitor disease progression or stability. A simple picture of a clock face drawn by a patient with early dementia when compared to their repeat illustration, can give incredible insight into the patients' disease. It can improve our documentation of chronic disease. A picture of a patient's self-recorded blood pressure readings can be efficiently recorded in their records with the click of a button.

For medico legal cases, clinical images can also be used to complement notes when a patient presents following an accident or altercation.

WHAT ARE THE ISSUES WITH CLINICAL PHOTOGRAPHY?

As time has moved on the quality of images taken by smartphones equals and exceeds what previously may have been considered the standard of standalone cameras. Smartphones are much more accessible and are much easier to secure with passwords, fingerprint and facial recognition.

The connectivity of the smartphone can be a problem though. If a GP uses it to take a clinical image it is important to make sure it does not automatically upload it to "the cloud" (which is essentially like a remote hard drive connected to via the internet).

A common question from those who use clinical photography is "how do I get the image from my phone to the computer safely and quickly?".

This is Thomas' area of interest.

"For me, this is the crux of clinical photography in general practice. Currently our options lie somewhere between using a wire to directly connect the smartphone to the desktop- key issues here include clunky method, time consuming, potential to spread of viruses from phone to computer. The next option may be to email yourself the image, here the issues really are that the email server (e.g. Gmail) is not a private or secure server, you also must delete the received email AND the "sent" mail.

These solutions did not satisfy me and so I felt compelled to develop my own."

SNAP GP

This is the clinical app which Thomas has developed to solve some of what he considers to be the significant issues with clinical photography on the smartphone for GPs.

What does snap GP do?

It allows a GP to take and send an image over secure cloud server directly to their computer safely and very quickly.

The patient signs the screen and this is embedded on the image (it is also date and time stamped).

The image is automatically deleted from the GP's phone once sent and cannot be uploaded to iCloud storage etc.

The GP can then upload the image from the folder easily into the patient consultation note.

"It is simple to download and use, it was designed by and for the developer so hopefully all GPs will find it as useful as myself."

CLINICAL PHOTOGRAPHY IMPORTANT THINGS TO KNOW:

Consent and confidentiality
Informed consent must be obtained prior to taking clinical photographs and the patient must be aware that the photograph will be used for treating and assessing the patient's condition. The photograph cannot be used for any other purposes without express consent of the patient. Clinical photographs are confidential medical records which may contain sensitive information. They should be treated with the same care as written medical notes. GPs should not store such clinical images on their phones.

Quality
It is the healthcare professional's responsibility to decide when it is appropriate to undertake clinical photography and consider the quality of the image produced to be sufficient. E.g. monitoring wound healing progress or deterioration, monitoring acne during treatment etc.

Taking the photograph:
- Protect the patient's identity within the photograph itself.
- Care must be taken to respect the dignity, ethnicity and religious beliefs of the patient.
- Maintain the patient's modesty at all times.
- Background should be plain and neutral.

Scale
Rulers (disposable paper ones are fine) must be used to give an impression of scale and the extent of the wound

Labelling
When choosing identification for the patient image – it is recommended to use the patient's initials and a numeric id.

Storage
The GP must:
- Have up to date antivirus software and ensure their computer is adequately secure.
- Ensure images are never uploaded to their personal cloud storage.
- Ensure their phone is adequately protected.

Summary

Clinical photography is used throughout medicine and can be used to great advantage in general practice. GPs are ideally placed to incorporate it into their daily clinical practice.

Utilising innovative technology to improve security and patient safety as well as the efficiency and quality of taking images makes using imaging very attractive in general practice.

Snap GP is being developed to utilise such technologies (**www.snapgp.com**). Available on iTunes November/ December 2017.

Please feel free to tweet Dr Thomas at **me@phluephotos** if you have any questions or inquiries regarding Snap GP.

BUILDING HIGH-PERFORMING TEAMS IN GENERAL PRACTICE

VALERIE O'KEEFFE IS A BEHAVIOURAL PSYCHOLOGIST, SEE WWW.CLARITYVP.IE

While it might sound like a straightforward concept, building a high-performing team in any industry is not an easy task. The two main stumbling blocks tend to be time and support – or more accurately, the lack of them.

As a leader in general practice, your first step is to stand back, observe and then assess what level you and your team are at in terms of performance. However, finding the space to carry out meaningful team analysis, amongst the demands of a busy general practice, is challenging to say the least. Add to that the heightened pressures on the role of GPs in Irish society today, and the task may seem simply overwhelming.

This is where support comes in. No matter what the industry, leaders almost always benefit from external help in working through team analysis. Engaging a third party, from outside your practice, makes it easier to carve out time to focus on what is a very important activity. Using proven business frameworks, this support allows you to follow a more structured approach and, in most cases, develop a defined plan of action.

Over the years, many leaders, including those from the medical sector, have come to ClarityVP seeking support in their 'team building' efforts. When we dig a little deeper, we often find that other areas need to be addressed first, such as strategic planning or stronger team alignment to goals. Whatever the starting point, it is heartening to support leaders as they work through the process, identifying the best people strategies to employ and taking definitive steps towards better team performance.

Once an informed plan is implemented, we can begin to see teams believe in themselves more, create greater momentum internally and exceed in the delivery of a patient-centred service. In this article, I will share some of the insights ClarityVP has used to help clients build their own high-performing teams.

THE IMPORTANCE OF TEAM PERFORMANCE IN GENERAL PRACTICE

In recent times, we have seen a steady increase in requests for support from GPs. It's no surprise really. Clinical care is becoming more complex and specialised. Higher patient volumes, an ageing population and a rise in chronic diseases, like diabetes, cancer and heart disease, mean that general practices have never been busier. This is further compounded by follow-up paperwork, test results, secondary care liaison and additional patient services. With this escalation in workload and responsibility to patients and their safety, there is now an intense strain on the profession.

In such an environment, working closely as a team has become more critical than ever.

Recruiting the right resources and having a strong collaborative team structure gives you the freedom to get back to your 'day job', safe in the knowledge that your team members, while each understanding their individual role, are acting as one to deliver the best possible patient care for your practice.

ClarityVP recently supported a medical practice through a phase of repositioning that yielded very positive results. Working with the GP and Practice Manager, we devised a new strategic approach to the market, reinvigorated the leadership team, introduced initiatives for wider team building and, ultimately, brought about a 25% increase in turnover.

TEAM DYSFUNCTION

So, you've managed to schedule adequate time and rally the support you need. Why then is it still so difficult to build a high-performing team? The answer lies largely in the fact that teams, by their very nature, can be dysfunctional.

I regularly refer to Patrick Lencioni's framework, The Five Dysfunctions of a Team, when supporting leaders in this area. It is extremely useful when establishing where the problems lie within a team dynamic and in developing a comprehensive plan for enhanced team performance.

The five team dysfunctions identified by Lencioni are as follows:
Dysfunction 1 - Absence of Trust
Dysfunction 2 - Fear of Conflict
Dysfunction 3 - Lack of Commitment
Dysfunction 4 - Avoidance of Accountability
Dysfunction 5 - Inattention to Results[1]

Using this framework, we can help practice principals to establish why a team is failing or why it has never reached its full potential. Figuring out the root cause of team failure enables leaders to determine where their team is currently positioned and what must happen to move it forward in a positive way. As Lencioni points out, the causes of dysfunction are recognisable and curable but 'making a team functional and cohesive requires levels of courage and discipline that many groups cannot seem to muster'. [2]

For those who can, the rewards are ample. Lencioni argues that teams who go the extra mile and are willing to address the five dysfunctions, set in train a system of high performance. Teams that understand their roles and responsibilities, operate with clear communication, hold each other accountable and share a strong collective ambition are more productive, more effective and happier.

EXTRINSIC VS INTRINSIC MOTIVATION

Now that you've determined the issues within your team and where you want to get to collectively, what can a practice principal do on an individual level to help build a high-performing team? Ascertaining what it is that drives each team member and the underlying nature of these motivations is key here.

For this, I turn to Frederick Herzberg's Two-Factor Theory of Job Satisfaction, which sets out two types of motivational influences on long-term career fulfilment. Extrinsic factors (like working conditions, job security, pay and benefits) are important but it is the intrinsic factors (like opportunities for promotion, personal growth, responsibility and achievement) which establish lasting job satisfaction. Leaders who correctly address the extrinsic/intrinsic motivational balance have the power to create teams that will 'go to the moon' for them. This is especially relevant in the demanding field of general practice.

THE CHARACTERISTICS OF HIGH-PERFORMING TEAMS

You've now identified and resolved team dysfunction and engaged each member on an individual level to better appreciate their motivations, but what should a high-performing team in general practice actually look like? In my opinion, there are seven major characteristics:

1. **Strong Level of Trust**
   As Ernest Hemingway said, 'The best way to find out if you can trust somebody is to trust them.' A strong level of trust within a team gives people the freedom to truly engage and to raise any concerns around team goals and aspirations. It also helps to create the right values set for your practice.

2. **Clear Sense of Purpose**
   Teams that crack this really fly, especially in general practice. Knowing why you are all together in the first place, who you are serving and what success looks like is key.

3. **Shared Set of Goals for Patient Care**
   If team members are involved in shaping goals, they are much more likely to follow through on them. Rather than dictating from on high, it is very important to include the team when setting goals and developing practice protocols.

4. **Defined Roles, Responsibilities and Accountability**
   Everyone is entitled to clarity when it comes to their role. Recognising the difference between responsibility and accountability is also essential to building a high-performing team.

5. **Members Playing to Their Strengths**
   Asking team members what motivates them helps you to learn about each individual's ambition. This, combined with having a good sense of their strengths, allows you to position them in a role that is best suited to them and your practice.

6. **Focused on Results**
   Measurement is crucial to sustaining team success. You should ensure that metrics are in place to measure both the hard results and the process in which the results are achieved.

7. **Open and Honest Communication**
   A team that has 'honest team talks' can handle most of the issues faced in business. Developing a culture of trust enables people to raise concerns or bring forward new ideas to support your practice in the future.

An understanding of these characteristics helps GPs to build high-performing teams. By devising a plan that supports real engagement, teamwork is promoted, greater collaboration is encouraged, sharing of knowledge is stimulated and a common sense of purpose is engendered.

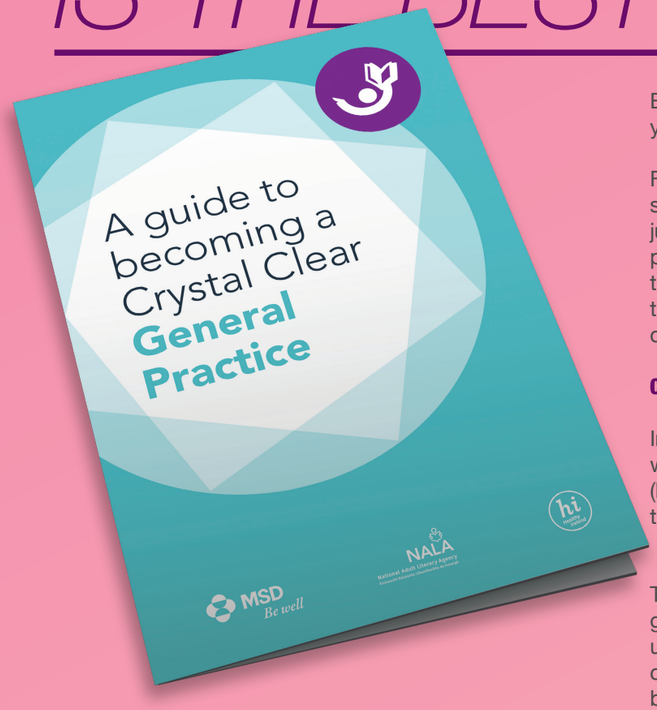
HIGH-PERFORMING TEAMS AND YOUR BOTTOM LINE

Despite the challenges, building a high-performing team is a valuable process for any general practice to engage in. By eliminating team dysfunction, understanding the intrinsic motivations of each team member and adopting the principles of high-performing teams, general practitioners can enhance the performance of their practices. This, in turn, strengthens patient care and improves the bottom line.

[1] Patrick Lencioni, The Five Dysfunctions of a Team – A Leadership Fable
[2] Patrick Lencioni, The Five Dysfunctions of a Team – A Leadership Fable

HEALTH LITERACY
IS THE BEST MEDICINE

By Helen Ryan, Policy Officer,
National Adult Literacy Agency (NALA)



The EU Health Literacy Survey[1] showed that four in ten Irish adults had limited health literacy. Other research[2] shows one in six Irish adults (521,550 people) find reading and understanding everyday texts difficult: for example, reading a leaflet, bus timetable or medicine instructions. One in four (754,000 people) has difficulties in real world maths, from basic addition and subtraction to calculating averages.

When dealing with health services, many adults find it challenging to:

1. read and understand health information
2. fully understand their health condition and treatment
3. work out and follow instructions on medicine labels
4. make informed decisions.

Health literacy and numeracy has two elements:

1. people understand health information correctly and can make an informed decision and
2. health services communicate clearly and take account of possible health literacy and numeracy needs.

Many health services are now looking at how they engage with their patients and particularly people who have literacy and numeracy needs.

By being aware and making it easier for all patients to use your services, you are becoming health literacy friendly.

For example, a general practitioner (GP) can look out for signs that a patient may not understand the instructions they just gave them. They might use teach back which asks the patient to repeat in their own words what they understand they have to do now. If the patient didn't understand fully then the GP can repeat the instructions perhaps using different terms and giving an example.

CRYSTAL CLEAR PROGRAMME

In 2015 Ireland's first health literacy quality mark was launched by the National Adult Literacy Agency (NALA), Merck Sharp and Dohme (MSD), along with the Irish Pharmacy Union (IPU) and Irish College of General Practitioners (ICGP).

The programme was developed to recognise the critical role general practices and pharmacies play in helping patients understand their health issues and the practical steps they can take to improve their health. We also developed a booklet to support general practices to become more literacy friendly and get the mark - it is available online at: http://bit.ly/2aZmts8. It is **free** to take part in the programme and the quality mark is given for **two years**.

HOW CAN YOU GET THE CRYSTAL CLEAR MARK?

1. Go to www.nala.ie/crystalclear and complete the online audit. The audit asks nine questions under four areas:
   - Policies and procedures – two questions
   - Communications – four questions
   - Staff awareness – two questions
   - Evaluating and improving – one question.

You must also supply evidence such as photographs of clear signage, examples of clearly written letters and ways that staff communicate effectively with people in a literacy friendly way.

2. NALA assesses your application and if you are successful, you get the Crystal Clear Mark. We will send you the mark in the form of a door sticker and certificate which you can display in your general practice.

3. If there is more evidence needed, NALA emails you and then talks to you over the phone to get the extra information. NALA also offers advice and support where possible. Once all the evidence is provided, you get the Crystal Clear mark.

TIPS FOR HEALTH SERVICES

- Communicate using plain English and follow design standards – see www.simplyput.ie for advice.
- Give clear, easy to follow verbal communication. Explain any medical terminology.
- Check that people understand what you have said. Ask people to repeat back to you:
  1. What is their main problem?
  2. What do they need to do?
  3. Why is it important they need to do this?
  [Taken from the Ask Me 3 Campaign]
- Ensure the layout of information and signage is clear and easy to follow.
- Ensure all staff are aware of literacy and numeracy issues and how to respond appropriately and sensitively. For example, staff might offer help with reading information and or filling out a form.

Further information
Helen Ryan
National Adult Literacy Agency
Sandford Lodge, Sandford Close
Ranelagh, Dublin 6
Web: www.nala.ie
Email: hryan@nala.ie
Tel: +353 1 412 7900

[1]The European Health Literacy Survey: Results from Ireland (2012)
[2]Programme for the International Assessment of Adult Competencies (PIAAC) 2012 Survey Results for Ireland

QUICK TIPS

INTRA UTERINE SYSTEMS

IUS continue to feature highly as a source of dissatisfaction for patients, leading to Medical Council complaints and claims against doctors. Perforation and migration are the most common reasons for the complaint. These are recognised risks for these devices. Medisec would like to remind doctors that they can afford themselves greater protection from litigation if they illustrate that they warned the patient about these potential hazards in advance. A comprehensive explanatory leaflet and inclusion of these potential ill effects on the consent form can be of great support in the event of a perforation or migration. The risk of perforation is increased in breast feeding women and during the post-partum period.
All patients should have a review six weeks after insertion. Not all patient information leaflets and consent forms provided include warnings about perforation and migration.

Medisec recommends that doctors ensure that the patient information leaflet and consent form used includes these references and that the risks identified are recorded in your medical records.

THE HAZARDS OF IRON INJECTIONS

Iron injections can cause subcutaneous brown staining, a recognised side effect. Remember to warn patients that this might occur and record your warning. Joint pain following iron injections has also been described, along with other undesirable effects described in the SPC of most iron injection preparations. It should be injected only into the muscle mass of the upper outer quadrant of the buttock - never into the arm or other exposed areas.
To avoid injection or leakage into the subcutaneous tissue, a Z-track technique (displacement of the skin laterally prior to injection) is recommended.

COMPULSORY PROFESSIONAL INDEMNITY

The Medical Practitioners (Amendment) Act 2017 came into effect on 6th November 2017. It is now mandatory for all medical practitioners currently registered or applying to register with the Medical Council to have professional medical indemnity up to a specified level which varies for different specialties. GPs must have cover up to €10 million. All applicants applying to register or renew their registration with the Medical Council must provide evidence of professional medical indemnity or they will not be placed on the register.

Medisec welcomes the introduction of compulsory professional indemnity for medical practitioners which provides further certainty for doctors and patients.

Medisec assures members that The Medisec Master General Medical Practitioners Professional Indemnity Policy underwritten by Allianz PLC provides our GP members with adequate professional indemnity cover to a level of €10 million in the aggregate.

Members can contact Medisec for further information on the new requirements.

RED ALERT

VACCINES – TIDY THE FRIDGE

We are well into the Influenza vaccination season and mass vaccination programmes are ongoing in GP practices across the country.

Medisec receives frequent calls from doctors looking for advice having inadvertently administered an out of date or wrong vaccine. While mostly this does not result in any harm to the patient we do advise that you immediately disclose the mistake to the patient and make arrangements for the correct vaccine to be given.

Make sure that vaccines contraindicated in pregnancy (e.g. MMR) cannot get mixed up with other vaccines.

There is no excuse for having out of date vaccines in the refrigerator. Tidy that fridge!

RISK REDUCTION-MEMBER SUGGESTIONS

At our Best Practice Conference a prize of four framed Medisec Posters was won by Rukshan Goonewardena for his suggestion that Medisec produce a poster reminding patients that they should have an annual medication review, and to remind their GP of same. Congratulations Rukshan. Here are some other really useful member suggestions for risk reduction received on the day- a big thank you to all contributors!

PUBLIC NOTICEBOARD

One member highlighted to colleagues to be careful if there is a publicly accessible noticeboard in the practice. Some members have experience of posters and notices being put up by unaffiliated third parties advertising complementary medical services etc. It could be construed that information on a practice noticeboard is endorsed by the GPs in the practice.

NO 'ADD ONS'

Another member illustrated a firm policy in their practice allowing no handwritten 'add ons' to prescriptions. All prescriptions are to be typed/computerised. The local pharmacy is alerted to this fact. As a result there is a much lower risk of any 'alterations' to the prescription on the way to the pharmacy, and all prescriptions were, by definition automatically recorded in the patient's file.

REFERRAL LETTERS

When sending a referral letter regarding a patient to an OPD, one member suggested sending a copy of the letter to the patient, as proof that the referral was in fact made.

VERY ILL/VULNERABLE PATIENTS

An excellent suggestion by one member was to have a list of especially vulnerable patients who were highlighted at reception and could be afforded same day appointments, urgent telephone call backs and not kept waiting where possible. The special status would be temporary in most cases, say while a patient was going through chemo or their clinical condition was particularly labile. Patients would be only on the list for a limited length of time.
An additional option would be to provide them with an actual 'Green Card' to produce at reception removing any doubt as to their status.

RECYCLING BINS

A member would like to raise awareness to GPs to occasionally check what staff are putting in the recycling bin, with particular emphasis on checking for any patient identifiable material which should have been shredded. Some practices have very firm shredding protocols, but others have looser arrangements. Make sure your recycling system is watertight!

TELEPHONE CONSULTATIONS

A drop down template for recording telephone calls and telephone consultations can make for ease of recording. One member has established such a template to aid with the accuracy of the subsequent record. Medisec would suggest recording time, person to whom the GP spoke, the advice given, whether a follow up appointment was made, and whether the patient was happy with the advice given. Any consequent prescription should be recorded and what arrangements for follow up or safety netting. Once a template is set up, the recording is very quick and can be completed while on the call.

Medisec is now connected to the secure email system Healthmail and it is our preferred means of secure communication with members. Many members are already using this service. If a member needs to send any confidential material from a Healthmail account to a Medisec email address they can be assured it is being sent through a secure system.

Further details and information on how to register can be reached at **https://www.healthmail.ie**. There is no charge for the service which is funded by the HSE and supported by ICGP.

Healthmail is secure because it works within a private bounded network. Transport layer security (TLS) connections are in place with all connected agencies. TLS provides an encrypted tunnel between the mail servers, ensuring the security and confidentiality of the data transmitted.

In the interests of patient confidentiality and in compliance with data protection legislation, when contacting us for medico legal advice, please do not provide information on the telephone or in an email to Medisec that would allow a patient to be identified.

OUT & ABOUT

We work closely with GPs, staff and other stakeholders to enhance services to our members, improve patient care and reduce risk. We offer workshops and talks to GP practices and training schemes, trainers' meetings, faculty meetings, small group CME and study days. Please contact our CEO, Ruth Shipsey at ruthshipsey@medisec.ie or by telephone 01 6610504 to tell us how we can help GPs and their practices.

Deirdre McCarthy presented to the ICGP summer school on "Medico legal challenges in general practice". Aisling Malone presented to the same meeting on "Medico legal considerations when treating your minor patient". Ruth Shipsey presented to the ICGP Trainee Conference on "Trends in GP medical negligence claims and Medical Council complaints - How best to reduce risk (and the pitfalls to avoid)". Dr Mary Davin Power presented at the ICGP winter Meeting on "Risk Management in Prescribing in General Practice".

SAVE THE DATE

Medisec will run a seminar on Saturday 3rd March 2018 "**How to deal with complaints and aggressive patients in general practice**". Further information will follow. To register your interest in attending contact us by email on **info@medisec.ie** or telephone **01 6610504.**

MEDISEC IS DELIGHTED TO SPONSOR THE ANNUAL ICGP MEDISEC QUALITY IN PRACTICE AWARDS WHICH ARE PRESENTED AT THE ICGP ANNUAL CONFERENCE AND AGM MEETING.

At the ICGP Annual Conference and AGM meeting Fintan Foy, CEO, ICGP; Suzanne Browne, Medisec; Dr John Brennan; Dr Tommy Lynch; Dr Kevin McCarthy; Dr Harry Comber; Ruth Shipsey, Medisec.

Aisling Malone joins Medisec as a Healthcare solicitor with over 6 years' experience of analysing and advising on the legal issues and challenges faced by medical professionals, including general practitioners. Aisling's experience to date in the context of clinical negligence claims includes investigating civil claims ranging from comparatively minor to catastrophic injuries. Her particular interest lies in the regulatory sphere and advising doctors who are the subject of complaints. Aisling also previously worked as In-House Legal Advisor to the Medical Council of Ireland.

Dee Duffy solicitor trained and worked in one of Ireland's largest law firms, where she advised medical indemnifiers and practitioners on issues of healthcare law. Dee represented medical professionals in disciplinary and regulatory matters, including before the Medical Council. She advised practitioners and their indemnifiers regarding participation at Inquests and with Commissions of Investigations and HSE / HIQA inquiries. Most recently, Dee worked as an associate in the Public and Regulatory Department of a leading law firm primarily for the Medical Council in investigating and preparing cases for Fitness to Practise Committees.

ONLINE RISK SELF ASSESSMENTS

Medisec is delighted to announce the launch of a new online practice audit service for members.

Medisec Online Risk Self Assessments might be just what you are looking for with regard to reducing exposure to risk in the practice, while at the same time fulfilling your obligation for the audit element of your Professional Competence Scheme. Undertaking a clinical or practice audit is one the key PCS requirements and can be one of the most challenging elements of the PCS scheme to complete.

The online Audit can be found via the members' section of our Medisec website, and there are topics relating to Prescribing, Health and Safety, Hygiene and Data Protection. We hope to add to these on a regular basis and update them continuously.

The results of the audit will be confidential to you. You can undertake one or many of these audits, but once an audit is completed, you cannot undertake the same audit for PCS purposes within the next five years.

These audits, once completed, will return a score for your information only. On re-audit and 'closing the loop', the hope would be that your score would be improved after some corrections have been undertaken in the practice. For an audit to fulfil Medical Council guidelines, it should represent 12 hours of work, including for example the time taken to prepare and put any changes in place and practice meetings to inform staff.

For further information please log on to the members' section of our website **medisec.ie**, contact us by email on **info@medisec.ie** or telephone **01-6610504**.

MEDISEC IRELAND

MEDISEC
IRELAND

We're always on call

While you're busy caring for your patients, Medisec are doing the same for you.

Medisec provide advice and guidance on practice, procedures, legal and ethical issues, medical council complaints, as well as professional indemnity insurance, with 24/7 support whatever the issue, however big or small.

And because we're owned by and run for GPs in Ireland you can be sure we always have the best interests of you and your patients in mind.

Medisec Medical Legal Advisory Team

Ruth Shipsey
Chief Executive

Suzanne Browne
Chief Operations Officer

Deirdre McCarthy
Senior Legal Counsel

Mary Davin-Power
Senior Clinical Risk Advisor

Aisling Malone
Legal Counsel

Sarah Keegan
Medico Legal Advisor

Call **1800 460 400**
or visit **medisec.ie**

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