MEDISEC ON CALL

Winter 2018

Around the clock support for the Irish GP community

SEASON'S

GREETINGS

MEDISEC ON CALL
winter issue 2018

Aisling Malone,
Legal Counsel, is Editor of Medisec on Call. If you would like to suggest a topic to feature in a future edition, or if you no longer wish to receive our newsletter, please email Aisling at ***aislingmalone@medisec.ie***

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WELCOME TO OUR WINTER NEWSLETTER

I am delighted to welcome you to the latest edition of our On Call newsletter and to bring you up to date with a snapshot of what we have achieved this year.

This year, we have answered approximately 2,000 advisory calls from our members and have dealt with 97% of those in-house. The Medisec legal team has also supported over 70 members facing Medical Council complaints.

We have been pleased to welcome three new solicitors to the Medisec team this year. Eimear Bourke, Niall Rooney and Claire Cregan joined us, bringing a wealth of medico-legal knowledge and expertise, for the benefit of the membership. Investment in our team is key to achieving our vision of recognition as the indemnity body of choice for GPs, offering high quality service and unparalleled response times. No query is ever too small and I would encourage you to avail of our membership support services and to telephone us at any stage if you have any queries or concerns. Over 96% of queries received are answered on the same day.

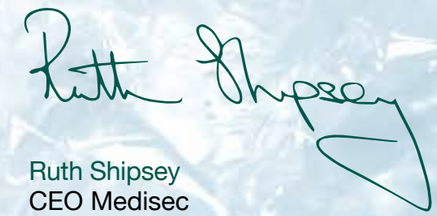
This year alone, we covered over 70 speaking engagements nationwide. Our education and risk management initiatives are key elements of our service offering and we always appreciate and enjoy the opportunity to meet our members in person. We welcomed over 120 new members to Medisec in the last year and we particularly look forward to meeting and developing relationships with those new members.

Medisec are proud to sponsor the annual ICGP Quality and Safety Award and this year commissioned Elizabeth O'Kane, an award-winning sculptor to design the perpetual award, on display in the ICGP Office. The award is an important initiative in promoting patient safety and quality of care in General Practice and we are particularly pleased to feature contributions from the finalists and overall prize winner in this edition of On Call.

As always, I am also most grateful to our guest contributors in this edition of On Call: Alison Kelleher, Solicitor and Partner of CKT Solicitors discusses reflective practice in the shadow of the Bawa-Garba case; Dr Tony O'Sullivan deals with Cryotherapy in Modern GP Practice; Stephen O'Leary BL reminds us of the Do's and Don'ts of Social Media; and Arthur Cush BL delves into the requirements for GPs to keep up to date and the Law.

We were delighted with the resounding success of our Best Practice Conference held in the Conrad Hotel, Dublin in mid-October and with the overwhelmingly positive feedback from the attendees. A full conference report is set out later in this issue. Our keynote speaker, Adam Kay delivered an engaging and very thought-provoking presentation based on his best-selling book, "This is going to hurt". We appreciate that there are many challenges and difficulties associated with daily GP practice and that it can feel stressful, isolating and sometimes overwhelming, especially if you find yourself faced with a medico-legal issue. I hope to reassure you of our continued empathetic support, advice and guidance at all times – we are only ever a phone call away.

Together with the entire Medisec team, I would like to wish you a very happy, peaceful Christmas and the best of health and happiness for 2019.



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OUR TEAM IS GROWING

WE'D LIKE TO INTRODUCE SOME NEW FACES WHO HAVE RECENTLY JOINED THE MEDISEC TEAM.

NIALL ROONEY

recently joined the Medisec team with a wealth of litigation and healthcare experience gained over the past decade. Prior to joining Medisec, Niall was a senior member of the Healthcare teams in Matheson and Eversheds Sutherland respectively, where he advised medical professionals and both public and private healthcare providers in relation to some of the most high profile medical negligence claims and Medical Council complaints in recent years. Niall has also significant experience representing medical practitioners at Inquests, as well as advising in relation to HSE and HIQA investigations, and on a wide range of medico-legal queries and challenges.

CLAIRE GREGAN

joins the Medisec team as a solicitor with a strong background in litigation and dispute resolution, having represented both Plaintiff and Defendant clients in all Irish court jurisdictions. Claire has experience in advising clients in respect of personal injury, catastrophic injury and clinical negligence claims. Claire more recently worked in the Public and Regulatory Department of a leading law firm where she advised healthcare regulators in the context of professional disciplinary matters. During this time, Claire primarily worked for the Medical Council and the Nursing and Midwifery Board in investigating and preparing cases for hearing before Fitness to Practise Committees.

EIMEAR BOURKE

joined Medisec's in-house legal team in 2018 after having trained and qualified as a solicitor with one of Ireland's premier law firms, McCann FitzGerald. Eimear has a keen interest in the healthcare sector and has completed a Diploma in Regulation and Disciplinary Proceedings in the Statutory Professions at the Law Society of Ireland. She particularly enjoys legal education and writing and has delivered lectures on a range of areas and been published in a number of leading international law journals.

RESEARCH UPDATE

One of the most commonly encountered potential risks to patient safety is the transfer of health information between secondary and primary care. Incorrect or omitted information can have a detrimental impact on continuity of care for a patient. In 2014, Medisec published a study in collaboration with the University of Limerick Hospitals Group and all stakeholders. The report is available on our website. We are pleased to present this follow on research by Dr. Róisín McNamara, Dr. Clíodhna O'Callaghan, Dr. Umbreen Salim, Dr. Ray O'Connor.

MEDISEC REPORT

A previous report published by Medisec Ireland CLG looked at information transfer between primary and secondary care. This study was carried out in the Mid-West between health practitioners in primary and secondary care. Analysis of the data from semi-structured interviews highlighted concerns particularly relating to medication errors. This concern was also noted anecdotally in practice. Poor quality discharge summaries and lack of clarification regarding medication initiation or alteration was a significant source of frustration and concern for General Practitioners. Often the patient presents after discharge from hospital looking for their prescription with medication changes. The GP may be faced with a hospital prescription or discharge summary that does not mention any medication changes including dose adjustments, medications started or medications on hold. This issue had been raised as a concern in the report as mentioned previously but it was felt in practice that little had changed since that time.

FINAL YEAR PROJECT

For our final year GP research project we decided to conduct an audit of discharge summaries from secondary to primary care. This study was published in the Irish Journal of Medical Science earlier this year. The full paper is available at: Irish Journal of Medical Science (1971-) https://doi.org/10.1007/s11845-018-1862-6.

METHODS

HIQA published a standard "National Standard for Patient Discharge Summary" in 2013 and we chose this document as the standard for our audit. Our aim was to compare current practice to this standard. The objectives of the audit were to identify areas of concern and highlight areas where patient safety outcomes could be improved. The audit was carried out by three GP registrars in practice across the Mid-West region. 60 discharge summaries were included in total over the time period from June- November 2017. These summaries came from a variety of hospitals- University Hospital Limerick, St. John's University Hospital Limerick, University Orthopaedic Hospital Croom, Co. Limerick, University Hospital Nenagh, University Hospital Ennis and Galway University Hospital. The HIQA standard listed criteria that were considered were: 'mandatory', 'optional' or 'mandatory where applicable'. The template for our audit was created using the 'mandatory' criteria from the HIQA standard which amounted to 12 criteria in total. The information was gathered by retrospectively reviewing the discharge summaries in the defined time period.

RESULTS

The results were analysed using descriptive statistics. Patients' baseline demographics were present in all cases. The address was present in 56 (93%) of cases. The gender was present in 10 (17%) of cases. The admission diagnosis was documented in all cases but co-morbidities were only documented in 43 (72%) cases. A complete medication list was documented in 42 (70%), however 36 (60%) had no documented changes to medications that were stopped or on hold. The speciality of the admission team was only completed in 8 (13%) cases.

This study showed that there are deficits in the transfer of information between secondary and primary care. There has been little improvement when the results of this study are compared to the Medisec study,also conducted in the Mid-West area in 2013.

It is widely accepted that secondary care providers also face challenges in the workplace, particularly an increased workload burden and staff shortages. Acknowledging the system challenges, the current practice is far from ideal and is not meeting the nationally accepted standard.

Possible reasons for this include lack of clarity regarding the discharging doctor's role and responsibility. Some clinicians may feel they are only required to include information relating to the reason for admission within their own specialty. They may also feel unable to comment on medication changes if it is not in their relevant area of expertise. Many NCHDs also feel they did not receive adequate training in completing discharge summaries. It has been shown in the USA that high standard discharge summaries have been developed in electronic format. Also brief educational interventions can improve the standard of discharge summaries. It is imperative that measures be taken to improve the quality of discharge summaries from secondary to primary care. This is particularly important for patient safety and continuity of care. It is also of great relevance for General Practitioners as a higher standard in the transfer of information from secondary care should also help to reduce the incidence of prescribing errors and adverse events.

References available on request.

REFLECTIVE PRACTICE IN THE SHADOW OF THE DR BAWA-GARBA CASE

BY ALISON KELLEHER,
Partner, Comyn Kelleher Tobin,
Medisec Panel Solicitors

18 February 2011	December 2014	November 2016	December 2016	June 2017	January 2018	March 2018	August 2018
J, a 6 year old patient dies of sepsis under the care of Dr Bawa-Garba at an NHS Hospital	Dr Bawa-Garba, and 2 nurses are charged with Gross Negligence Manslaughter	Dr Bawa-Garba is found guilty of Gross Negligence Manslaughter (given a 2 year suspended sentence and ordered to pay costs	Dr Bawa-Garba is refused permission to appeal the GNM conviction	Medical Practitioners Tribunal suspends Dr Bawa-Garba for 12 months	GMC appeal the MPT decision to the High Court where Dr Bawa-Garba is struck off	Dr Bawa-Garba appeals the High Court decision to remove her from the register	Dr Bawa-Graba wins an appeal against GMC's appeal and the Court of Appeal reinstates the 12 month suspension.

BACKGROUND

During the early hours of 18 February 2011, a 6 year old boy, J, was admitted to an NHS Children's Assessment Unit with diarrhoea, vomiting and difficulty breathing. He had Down's syndrome and an atrioventricular septal defect repaired as an infant and was on Enalapril.

Due to staffing issues, Dr Bawa-Garba, a Paediatric Registrar on her first shift following maternity leave was in charge of the paediatric emergency department without a senior consultant on-call. It was her first day working at the hospital and she received no induction training. The morning handover was not completed due to an emergency. On review at 10.30, Dr Bawa-Garba found J to be dehydrated and acidotic. Dr Bawa-Garba diagnosed hypovolemia and ordered fluid replacement, blood gas (taken at 10.45), blood samples (taken at 11.00) and a chest X-ray (performed at 12.00). The blood gas taken at 10.45 revealed profound metabolic sepsis but was not reviewed by Dr Bawa-Garba.

Dr Bawa-Garba reviewed the chest x-ray at 15.00, identified left upper lobe pneumonia, and prescribed IV antibiotics which were given at 16.00. At 16.00 she reviewed the blood results which indicated sepsis and organ failure.

Dr Bawa-Garba spoke with the on-call consultant who started his shift at 16.00. She did not ask the on-call consultant to review J but did advise him of abnormal blood results and he did not review J.

Dr Bawa-Garba deliberately omitted Enalapril from the drug chart but she did not make it clear to the child's mother not to give it and it was subsequently given that evening by the child's mother, resulting in circulatory shock.

Earlier that day, Dr Bawa-Garba had admitted a terminally-ill child with a DNAR order to the side-room on the ward. At 19.00, J was transferred from CAU to the same side-room on the ward. At around 8pm J began to deteriorate further and he suffered cardiac arrest, CPR was commenced, and endotracheal intubation was carried out. Dr Bawa-Garba attended the cardiac arrest call to the side-room believing it to be the DNAR child she admitted earlier and requested the team to stop resuscitation. Within two minutes she realised it was the wrong patient and CPR was recommenced. J died of a cardiac arrest as a result of sepsis at 21.20 that evening.

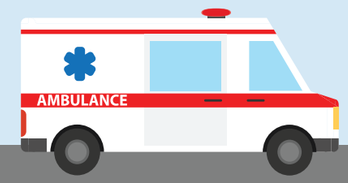
GROSS NEGLIGENCE MANSLAUGHTER

Dr Bawa-Garba, a staff nurse and the ward sister were tried for gross negligence manslaughter at Nottingham Crown Court. The allegations were complex but essentially related to:

- Inadequate initial assessment (10.45-11.00) after receiving blood gas results
- Ignoring obvious clinical findings and symptoms at review at 10.45 and again at 15.00
- Delayed review of X-ray from 12.15 to 15.00
- Insufficient blood samples obtained at 12:12 for repeat blood gas
- Failure to make proper clinical notes recording assessments and timings
- Failure to ensure antibiotics given timeously
- Failure to obtain blood test results ordered at 10.45 until 16.15
- Failure to act upon obvious clinical findings and blood results indicating infection and organ failure from septic shock
- Failure to raise concerns; other than flagging CRP and diagnosis of pneumonia, to consultant
- Reporting of improved picture to consultant at 18.30
- DNR mistake not causative but indicative of lack of care

With the support of expert evidence, a defence was put forward as follows:

- A full history was taken; necessary tests carried out on admission
- At 11.30-11.45 there was reassuring improvement (albeit not documented) following fluids
- 12.12 blood gas reading showed clinical signs of improvement; with J sitting up and laughing
- Correct approach taken to administration of fluids given J's heart condition
- IT system failure from 11.00 to 16:30 delayed the blood results
- Key information including infection markers, patient history and treatment had been flagged to Consultant at 16.00
- Nursing shortage meant greater reliance on agency nursing, including co-defendants
- Nursing failures to properly observe; communicate deterioration and X-ray results turning off oxygen Sats monitoring, delay in administering antibiotics from 15.00 to 16.00
- Subsequent transfer to ward and administration of Enalapril was outside of her control.
- DNR mistake at the end of a 13 hour shift without a break was quickly corrected and made no difference to the outcome.



The jury returned a majority 10-2 verdict in favour of a conviction of Dr Bawa-Garba and the staff nurse but the ward sister was acquitted.

The jury was directed that it had to be proved that Dr Bawa-Garba's actions were "truly exceptionally bad" to find her guilty. A majority 10-2 jury found Dr Bawa-Garba guilty of gross negligence manslaughter. The Court of Appeal refused Dr Bawa-Garba's application to appeal.

HAS THIS HAPPENED BEFORE?

The Crown Prosecution Service in England and Wales, have provided the following statistics relating to 2013 – 2018:

- 151 cases of suspected gross negligence manslaughter by healthcare professionals
- In 85 cases, no further action taken by police
- Of remaining 43 cases, 13 did not proceed, 16 still under review
- 15 healthcare professionals have been prosecuted for gross negligence manslaughter
- 6 convictions, 2 subsequently overturned.

COULD IT HAPPEN HERE IN IRELAND?

To establish a conviction of gross negligence manslaughter in Ireland it is necessary to prove:

- that the accused was, by ordinary standards, negligent;
- that the negligence caused the death of the victim;
- that the negligence was of a very high degree;
- that the negligence involved a high degree of risk or likelihood of substantial personal injury to others.

It should be noted that:

- The test for GNM in England and Wales is slightly higher than the test in Ireland, in that it requires a high degree of risk of death rather than a (lower bar of) substantial personal injury.
- Whilst the rate of conviction in UK is described as rare, there has never been a conviction in Ireland for GNM in a medical context.
- The concept of "gross negligence medical manslaughter" in Ireland is vague and there is, as yet, no distinction between a doctor who consistently makes mistakes or one who makes one bad judgement call under pressure.
- The crime is "outcome focussed" in that it must cause death, whereas a similar act which did not cause death may not constitute a crime.
- The Corporate Manslaughter Bill 2016 is still in draft form but, if passed, may see a move away from individual liability to liability for the corporation involved, for example a hospital could become liable for deaths of patients due to system failures.

FITNESS TO PRACTISE

Following a four day hearing, the Medical Practitioners Tribunal Service (MPTS) suspended Dr Bawa-Garba for 12 months on 13 June 2017.

The General Medical Council (GMC) appealed the decision, arguing that suspension was not sufficient to protect the public or maintain public confidence in the medical profession and Dr Bawa-Garba was struck off by the High Court on 25 January 2018.

On 13 August 2018, Dr Bawa-Garba won an appeal against her erasure.

The Court of Appeal did not question the conviction of GNM although it acknowledged that a Criminal Court was not well placed to take account of the systemic issues which compounded deficiencies in care.

It found that the MPTS' role was to protect the public and to decide an appropriate sanction to meet that objective. The Appeal Court noted that the Criminal Court and Jury had a distinctly different role to determine Dr Bawa-Garba's guilt or absence of guilt in the past. The Court found that the MPTS was fully entitled to take into account the systemic failings that had contributed to the events as well as Dr Bawa-Garba's personal circumstances and the 12 month suspension was reinstated.

The decision of the Appeal Court has been widely welcomed by the medical community and has been accepted by the GMC who issued the following statement;-

"*Although gross negligence manslaughter cases in medicine are extremely rare, this case has exposed a raft of concerns, particularly around the role of criminal law in medicine, which is why we have commissioned an independent review to look at how it is applied in situations where the risk of death is a constant, and in the context of systemic pressure.*"

REFLECTIVE PRACTICE

In the UK, Doctors are required by the GMC to keep reflective learning material in an e-portfolio as part of their training. Concerns were raised that this material was used against Dr Bawa-Garba. It has since been clarified by her indemnifier that it was not used in either her fitness to practise hearings or the criminal process but it had been seen by expert witnesses.

Nevertheless, it is clear that clinicians are concerned about being honest in their own reflective learning and the GMC has issued guidance on making reflective notes in response to those concerns.

In Ireland, private recorded reflections are not subject to legal privilege and disclosure may be ordered by a Court if they are considered relevant to criminal, regulatory or medical negligence proceedings and care should be taken before preparing any such reflections in your own practice.

These "reflections" can be distinguished from statements or correspondence prepared either:

- for the "dominant purpose" of seeking legal advice or
- prepared in contemplation of litigation.

Such statements should, ordinarily, be privileged and therefore exempt from admission in legal proceedings but for the avoidance of doubt, if there are any concerns about disclosing any such statements, advice should be sought from Medisec.

CONCLUSION

GPs should be reassured that whilst the Irish threshold for GNM is lower than England and Wales, based on past trends it is less likely that a clinician will be prosecuted for GNM in Ireland and it is even more unlikely that there would be a criminal investigation where death was caused by an unintentional clinical error.

[1]The People (Attorney General) v John Dunleavy [1948] 82 I.L.T.R 7.
[2]Ireland has 22,649 registered doctors against England and Wales' 216,451.
[3]https://www.gmc-uk.org/-/media/education/downloads/guidance/the-reflective-practioner-guidance.pdf

We are pleased to introduce the latest release in our series of practice posters, designed with a focus on patient education and risk management. Unfortunately, we frequently hear of members and their practice staff being subjected to disrespectful communication and we developed this poster in response to that feedback. It is intended as a simple reminder to patients that respectful communication is a two-way street and that your policy is not to tolerate anything less.

TO ORDER A FREE POSTER FOR YOUR SURGERY, PLEASE CALL US AT 01 661 0504 OR EMAIL INFO@MEDISEC.IE

AN OVERVIEW OF THE ASSISTED DECISION MAKING (CAPACITY) ACT 2015

Assisted decision-making is relevant to patients who require (or may shortly require) help with their decision-making; for example, individuals with intellectual disabilities, head injuries or elderly patients. Below we explain the changes that will be brought about regarding assisted decision-making when the Assisted Decision Making (Capacity) Act 2015 (the "**Act**") becomes law. Although the Act was signed by the President on 30 December 2015, and although certain limited provisions have been commenced, most of the Act is not yet operative law. It is expected to be fully commenced by the 1st quarter of 2020.

AN OVERVIEW OF THE CHANGES THAT WILL BE BROUGHT ABOUT BY THE ACT

Once fully implemented, the Act will do away with outdated legislation such as the Lunacy Acts and will allow persons with impaired capacity to have greater control over decisions that may affect their welfare, property and affairs. This will affect how GPs interact with such patients and a GP may be asked to assess capacity for the purposes of implementing decision-making supports. The Act will also allow all individuals to determine their desired health treatment in the event that they lose capacity to make such decisions in the future.

The key changes introduced by the Act include:

- A definition of capacity which provides that a person "shall be assessed on the basis of his or her ability to understand, *at the time* that a decision has to be made, the nature and consequences of the decision to be made by him or her *in the context of available choices at that time*". This assumes capacity unless the contrary is shown. Capacity is only assessed in relation to the matter in question and at the time in question. If a person is found to lack decision-making capacity in one matter, this will not necessarily mean that they lack capacity in another matter.
- A decision-making support system for impaired persons and a tiered framework in relation to same (see further information below).
- A legal framework that will allow all persons to make legally binding Advance Healthcare Directives (see below).
- Abolition of the outdated Wards of Court system (see below).
- A modern regime for Enduring Powers of Attorney. These may now extend to healthcare matters.
- A Decision Support Service ("**DSS**") tasked with increasing public awareness, providing information and guidance, developing codes of practice and advising State bodies among other items.

CHANGES GPS SHOULD BE AWARE OF

GPs should be aware that going forward the focus will be very much on the rights of the individual and implementing their known wishes and preferences. GPs should bear this in mind when dealing with persons who have impaired capacity or items that relate to this area.

DECISION-MAKING SUPPORT SYSTEMS

The Act creates three new forms of decision-making support. GPs should familiarise themselves with each of these. The extent of impaired capacity will determine which form of support is appropriate. The three forms are explained in greater detail below (ranging from where the least assistance is required to the most severe cases).

1. Assisted decision-making

An adult whose capacity is impaired (or whose capacity is in danger of becoming impaired) may choose another adult to assist them with decision-making. Typically this person would be a family member, or carer. The assistant will explain the decision to the person and help them understand and make the decision themselves. The arrangement should be documented in a formal decision-making assistance agreement (the content and formalities of which are as yet unknown until future regulations provide clarity).

2. Co-Decision-Making

An adult whose capacity is impaired may appoint someone to jointly make decisions with them. The key difference between this form of support and assisted decision-making, is that the person with impaired capacity will not make the final decision on their own, rather it will be made with their co-decision-maker. The co-decision-maker should be a relative or close friend, such that a relationship of trust exists between them. The arrangement should be documented in a formal written agreement and this should be registered with the DSS within 5 weeks of signing. Notice of registration should be given to certain family members specified in the Act.

3. Decision-making representation

For adults who are not able to make decisions, even with help, the Circuit Court will appoint a decision-making representative. Any person with a genuine interest in the welfare of the impaired person may apply to the court to have a representative appointed - this could include a GP. If appointed, a decision-making representative will make decisions on behalf of the person but must abide by the person's will and preferences where possible. The functions of decision-making representatives will be as limited in scope and duration as is reasonably practicable. The decision-making representative must keep records and send reports to the DSS.

Where a GP is dealing with a patient who is being assisted in their decision-making, the GP should be careful to keep complete and detailed notes of all their dealings with the patient. If a GP has concerns in relation to any of the above, or is worried about a patient who is being assisted with their decision-making, the GP can lodge a complaint with the Director of the DSS.

ADVANCED HEALTHCARE DIRECTIVES

When the Act comes into force it will allow any person with capacity to make an advance healthcare directive ("**AHD**"). The purpose of the AHD is to enable a person to be treated according to their will and preferences in the event that they lose capacity in the future (for example, if they are in a coma). AHDs are not applicable to mental health treatment and will not be complied with where a patient is suffering from a mental disorder and is involuntarily detained under the Mental Health Acts.

AHDs will provide GPs with important information about their patients in relation to their treatment choices. AHDs may include refusals of treatment. This may extend to a refusal of life-sustaining treatment, however in such circumstances the AHD will need to contain an express statement that the AHD is to apply even if their life is at risk. If an AHD provides that the person did not wish to receive treatment the GP should honour this (provided that the patient had capacity at the time of making the AHD). If a patient requests a specific treatment in an AHD this will not be legally binding, but it should be taken into consideration by the GP if it is appropriate to do so. In the event that the specific treatment is not provided reasons should be given and documented.

A patient may also use an AHD to appoint a designated healthcare representative to make healthcare decisions on their behalf when they no longer have the capacity to make those decisions.

As above, GPs should ensure that complete, detailed and contemporaneous notes are kept when dealing with AHDs, and that their rationale for acting in a given manner is noted in all circumstances. If there is any ambiguity in the AHD, the GP should consult with the designated healthcare representative (if one has been appointed) or family members.

WARDS OF COURT

Once the Act comes into force no new Wards of court will be ordered. All current Wards will be reviewed in accordance with the new system set out above. A Ward who is found to have capacity will be discharged and their property will be returned to them. Where a Ward is declared to lack capacity, they will be discharged and offered the form of support most appropriate to their needs (e.g., a co-decision-maker or a decision-making representative may be appointed).

NEXT STEPS?

The HSE is doing a number of things to prepare its staff and services in advance of the anticipated commencement date in 2020. The DSS will need to be fully developed before the Act can come into force. The HSE has a dedicated assisted decision-making website, which can be accessed at **www.assisteddecisionmaking.ie**.

In the meantime, GPs should familiarise themselves with the provisions of the Act and the way decision-making will work when the Act comes into force as patients are already seeking guidance. As always, GPs should keep very precise notes of their consultations with patients and should ensure where possible that the will and preferences of the patient are given due regard. Members with specific queries can contact Medisec at any stage.

CRYOTHERAPY IN PRACTICE

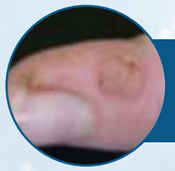
BY DR TONY O'SULLIVAN,
Irishtown Primary Care Centre
Dublin 4

There are a few surgical skills that every GP should master. One is the skill of lesion recognition, preferably including the use of a dermatoscope, and another is cryotherapy.

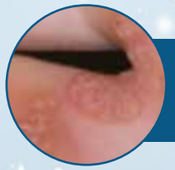
Many skin lesions are amenable to cryotherapy, most of them common and benign. This article discusses some of the issues we need to consider in the use of cryotherapy in everyday general practice.

Skin lesions

The principal benign lesions we treat routinely with cryotherapy are warts, including plantar warts, seborrheic and actinic keratosis. Warts need aggressive freezing, keratoses do not. When treating warts, we are not trying to kill off the wart virus, rather we create a skin defect at the site, and hope the patient's immune system will attack the virus subsequently.

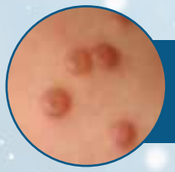


Common Wart



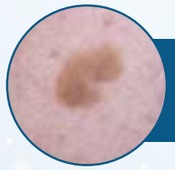
Plantar Warts

Molluscum contagiosum can be frozen , but often the patient's young age precludes this.

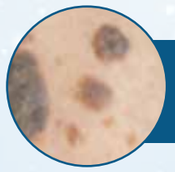


Molluscum Contagiosum
Smooth pearly lumps

Seborrhoeic keratoses are a benign but common nuisance for many patients. Sometimes you will listen to someone's chest and realise they are thoroughly encrusted with these. More often though, you will find one young lesion and then detect a few more with a close examination of sun-exposed skin. While they start off as light grey patches, they eventually develop into thick brown lesions. A characteristic feature is that they feel rough to the touch, often more readily felt than seen, especially among freckles and other pigmented lesions. Early treatment is easier and very effective, although the problem returns over time requiring repeated treatments.

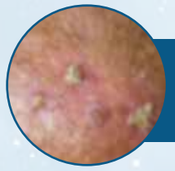


Early seborrheic keratosis



Late seborrheic keratosis

Actinic keratosis is perhaps more sinister. It often covers large areas of skin, eg on the forehead, scalp or hands, and can be crusty and uncomfortable. It does have the potential to develop into squamous cell carcinoma, hence treatment isn't entirely a discretionary cosmetic exercise.



Actinic keratosis
Several crusts on pink, not angry, background

Some people freeze skin tags. They have a great blood supply and are quite resistant to cryotherapy. For me, excision using electrocautery under local anaesthetic is the most minor of minor surgery, and the lesion is instantly removed and can be sent to histology. Freezing a skin tag reminds me of the Victorian method of tying string around a tag, then waiting for it to die and drop off. No, please!

Skin tags

Malignant lesions

Using a destructive process removes any opportunity for histological diagnosis, therefore is reserved for lesions that are clearly, recognisably benign. When there is any doubt, it is better practice to start the process with a biopsy. Any possibility of melanoma adds further difficulty, as a punch biopsy through the lesion is not recommended, and all likely melanomas now need to be sent to the regional melanoma clinic for diagnosis.

Cryotherapy Risk

Cryotherapy carries some risks, and in the context of a frequent procedure in practice, we need to remember that patients don't know what to expect. An information sheet helps.

Pain is common and can be anticipated. Usually at the time of the procedure and for a few hours afterwards. Advise pain medication, and freeze only manageable segments at a time (eg avoid treating multiple warts on both hands in a 10 year old). Some operators use local anaesthetic before treating heavily affected fingers, for example, and studies have shown that the experience of pain is reduced by this approach.

Blistering is usual after 15-20 second freezes, generally used for wart treatments. This may be deep enough to form a blood-filled blister. Remember to warn the patient to expect it. Advise them to leave these to heal naturally and remember, wart viruses exhibit the Koebner phenomenon, so if the patient pulls skin off, this can trigger new warts to grow.

Depigmentation happens because pigment cells are especially sensitive to cold. This is important if treating lesions on the face, but also in tanned people or dark skinned races. This can be a long term or permanent issue, so prevention deserves some attention.

Consider especially short freeze times (5 seconds can be adequate for a lot of lesions, but not warts), and only treat small areas at a sitting, perhaps a less visible 'trial' area first. Or consider an alternative or no treatment.

Scarring occurs after more prolonged freezing, and can be unpredictable. This needs to be discussed when seeking consent.

Recurrence is an important issue. Advise patients to return if the treatment hasn't worked, and this can help capture the innocent actinic keratosis that actually was something more sinister. While warts can be re-treated, anything else that a usually-adequate spray does not eradicate needs careful re-assessment, and biopsy and/or referral.

Patient selection and consent

Age alone cannot be used to decide who can tolerate cryotherapy. I've met some stoical 7 year olds, and some nervous 12 year olds. I believe in giving the control to the child, letting them encourage me, and checking with them frequently to see if they are tolerating the procedure. In this context, repeated visits are possible. We never use restraint for what is essentially a cosmetic treatment for children of any age.

In adults, we have to balance their desire for treatment with our capabilities and the scale of the problem. Ensure the patient knows what lesions are being treated, and why. There are no real contra-indications but look at previous scars and consider whether cryotherapy is appropriate in the presence of reduced immunity.

Consent is paramount these days, and must include specific mention of the common adverse outcomes including pain, scarring and de-pigmentation. Patient information leaflets are invaluable. If you offer one, record that you advised that the patient read it!

Equipment and techniques

Practitioners used to be divided between those using carbon dioxide with a large cylinder and a closed system passing the gas through a probe, held against the lesion being treated, and liquid nitrogen spray. The liquid nitrogen has largely won that battle, because of its versatility, and because you can treat large areas and potentially infectious lesions without touching them. CO_2 still has its adherents however.
Liquid nitrogen, can be stored in the practice and transferred carefully into a spray gun when needed.

CRYOTHERAPY IN PRACTICE

Safety Points:
A couple of safety points :

- Keep the large flask in a safe, cool place, relatively inaccessible to passers-by.
- The flask lid should be loose, or have a functioning pressure release valve.
- The method for transfer should be safe and effective with minimal risk of spills. Never transfer liquid nitrogen in a room with the door closed, and don't carry flask or spraygun inside a car. There was sadly a recent case of suffocation in a car due to dry ice (frozen CO_2) being carried inside. Rarely will you need to more than half-fill the gun, and always return unused liquid nitrogen to the flask.

Typical liquid nitrogen cryogun

Freezing with liquid nitrogen is convenient, quick, safe and highly effective. Cryoguns come with a selection of spray tips with different sized nozzles, and since a small amount of pressure builds inside, liquid nitrogen can be sprayed in a very controlled way, allowing a 'painting' approach to be used over large areas or multiple sites. It can also be directed down an auriscope cone to focus on a very small area, and can be passed through 'cryoprobes' of varying sizes to achieve adherence to a lesion.,

When freezing a lesion, ensure good light and that the patient is in a comfortable position. This may well be standing, because the cryogun prefers to spray horizontally. Hold the gun around 2-4 cm from the lesion, and spray continuously for 2 seconds or so, and repeated until the lesion is clearly frozen, with a 2mm margin of ice around it. Only now should you start counting the seconds for your desired freeze time. Thereafter, only spray in short bursts to maintain this ice-ball.

Use a timer to count the duration of freezing, and be disciplined about this. Not only is that good defensive practice, but if the treatment is ineffective, you'll be freezing for a little longer next time, so it's important to record your freeze times.

Wart treatment
Thick warts can be shaved down a little first using a no.10 scalpel. This improves the penetration of cold into the base of the wart. Then, warts need to be frozen solid for 15-20 seconds and this repeated as soon as they have thawed.

Rather than planning repeated treatments, I feel that recurrence indicates that the patient's immune system is not ready to react to the wart virus. I generally anticipate success first time, and would not repeat treatment more than once, around 4 weeks later. At review, removal of dead skin may reveal that the wart has already been successfully treated.

Some sites need special care, for example around the nail bed. The vermilion border and nail matrix are sensitive and real caution is needed to prevent permanent damage to nail growth. Use shorter freeze times and spray carefully to avoid collateral damage.

Seborrhoeic keratosis
A single freeze is usually adequate for these very superficial lesions. Duration depends on how thick they are. 5 seconds is adequate for young thin lesions, but thicker ones may need up to 12 seconds. Some are so thick that freezing cannot get rid of them, and you may need to resort to shave excision under local anaesthetic. People affected by these lesions tend to grow new ones over time, so predict the need to treat new lesions every year or two.

Red Flag
The recurrence of a seborrheic keratosis at a single site soon after treatment should always raise the possibility of a different diagnosis, including melanoma.

Actinic keratosis
These lesions are more vague with indistinct margins, often more widespread in an area of skin and can recur quite promptly. Treatment is worthwhile, since there is a risk of progression to malignancy. There are alternatives to cryotherapy, including chemical treatments and shave excision, but I find freezing convenient and successful. The approach here may be spot freezing, but in some cases is more akin to spray painting. Get up close in good light, feel the lesions to assess the degree of crustiness, use dermoscopy to assess any more sinister changes in underlying skin, then let the artist in you take over!

Actinic keratosis requires very short freeze times, from 3-5 seconds, so covering an affected area doesn't hurt as much as it sounds, and problems like depigmentation happen less often, although the warning is required - the most commonly affected area is the forehead and scalp. Patients should be advised to moisturise the skin – I advise 'Simple' moisturiser with built-in factor 15 spf. Regular review for short treatment sessions is the way forward here. Resistant or recurrent lesions again need careful review and should be biopsied.

Summary
Cryotherapy is a very effective, safe and accessible treatment for benign skin lesions which is wholly appropriate to general practice. In my view every practice should use this treatment, one of the few which is actually profitable even in the GMS.

Some initial requirements include becoming familiar with relevant skin lesions and improving recognition of malignant lesions, preferably with assessment by dermoscopy. A small investment in suitable equipment, ensuring safe storage for liquid nitrogen, careful patient selection and well informed written consent are important.

When treating, consider a small sample area in pigmented skin to assess the balance between effectiveness and depigmentation; tend towards under-treatment initially, record formal freeze-times using a clock once an ice-ball has formed, and reconsider the diagnosis in resistant or recurrent lesions.

Finally, it makes sense for anyone using cryotherapy and other surgical treatments to join a community of GPs with an interest in skin surgery. Our website holds lectures on cryotherapy from our 2017 conference.

Join today at www.pcsa.ie .

BEST PRACTICE CONFERENCE 2018

Medisec hosted their annual 'Best Practice' Conference on Saturday, 13 October 2018, in the Conrad Hotel in Dublin. The theme of this year's conference was 'Perils in Practice: the Practicalities' and Medisec was delighted to welcome over 150 General Practitioners and guests from across the country.

The conference was opened and chaired by Ruth Shipsey, Medisec CEO and Dr John O'Brien, President of the ICGP gave a warm welcome address.The agenda for the day included national and international speakers and the topics were of interest to GPs across the country who are committed to reducing their levels of exposure to risk in general practice.

The morning began with Dr Ray Walley, a GP in Finglas, providing a tutorial on managing difficult patients. Dr Walley gave invaluable insight on the GP experience in both Ireland and in the UK and outlined some of the difficulties that GPs are currently facing. He gave a number of useful tips and tricks for dealing with aggressive patient behaviour. This can be a very difficult area for many GPs and all were grateful for the sage advice given.

Dr Walley was followed by Ms Alison Kelleher, a solicitor and partner in Comyn Kelleher Tobin Solicitors. Ms Kelleher spoke on critical incident management. She outlined the steps that General Practitioners should take when things go wrong and gave an overview of the recent Bawa Garba case in the UK and the implications that this case has for reflective medicine and open disclosure.

Next to the podium was Mr Jack Nagle; Mr Nagle is CEO of Alpha Primary Care, a company that provides support to GPs and healthcare providers by advising on security and regulatory requirements in practice.

Mr Nagle gave down to earth advice on how small changes in practice systems and environments can go a long way to enhance safety.

Dr O'Brien, Dr Walley, Ms Kelleher and Mr Nagle then engaged in a Q&A session with Ms Shipsey and with the audience before breaking for some well-deserved treats and coffee served by the Medisec barista.

Keynote speaker, doctor, author and comedian, Dr Adam Kay then took to the stage and entertained the audience with some amusing and heartfelt stories from his best-selling memoir "This is Going to Hurt", which recounts his time as a junior doctor.

Members of the Medisec legal and clinical advisory team then sat down for a fire-side style chat with the audience and provided practical advice on how to manage complex doctor-patient interactions. Solicitors Niall Rooney and Aisling Malone provided advice on topics ranging from sexually active underage patients to capacity and fitness to drive, while GP Dr Mary Davin-Power dealt with clinical areas such as benzodiazepines, confidentiality and transcribing prescriptions.

The day concluded with a networking lunch. All proceeds from the day went to Médecins Sans Frontières. Medisec wish to thank all their speakers and attendees for contributing to a very successful and thought provoking conference.

Adam Kay


Hugh Governey and Fintan Foy


Ruth Shipsey and Prof Andrew Murphy

The Medisec Team


Prof Walter Cullen and Adam Kay with students UCD Med School


Aisling Malone and Brian Langton


Mary Davin-Power, Niall Rooney, Ruth Shipsey, Aisling Malone


Michelle Moore and Prof Tom O'Dowd

Dr Ronan Boland, Dr Mary Gray, Niall Rooney


Suzanne Browne and Sam Taylor, MSF Ireland

Ruth Shipsey, Jack Nagle, Dr Ray Walley, Allison Kelleher, Suzanne Browne, Dr Mary Davin-Power, Dr John O'Brien

SOCIAL MEDIA

DO'S & DON'TS

BY STEPHEN O'LEARY, BL

Social media is a part of daily life. It is a useful of way of keeping in touch with friends and family, sharing useful information with colleagues and raising awareness of public health issues both with patients and the wider public. There are, however, a number of potential pitfalls. The risks are higher for those who provide professional advice. The good news is that a few simple steps can significantly reduce that risk.

MEDISEC POLICY

The Medisec[1] professional indemnity insurance policy includes the following as constituting malpractice:

"unauthorised use of confidential information of a patient of the Practice or other breach of professional confidentiality in respect of a patient of the Practice.

"Defamation, arising from the Practice and committed in good faith".

While the policy will indemnify you in respect of a breach of a patient's privacy, it is important to note that for defamation, the policy only covers you where the defamatory comment arises from your practice. You are not covered for any defamatory comments which do not directly arise from your practice or for comments which are deemed to made with malice, even if they arise from your practice.

DEFAMATION

Defamation is defined[2] as publication, by any means, of a defamatory statement concerning a person to one or more than one person (other than the person about whom the statement is made). A defamatory statement can therefore be either a written or spoken statement. The distinction between libel and slander has been abolished by the Defamation Act, 2009.

It is worth remembering that defamation is not limited to individuals and a corporate entity is also entitled to sue for defamation.

MEDICAL COUNCIL GUIDELINES

Recognising the increasing use of social media, its benefits and the potential risks it poses, the Medical Council's Guide to Professional Conduct & Ethics (8th edition, 2016) now contains an entire section on social media. Much of the advice is common sense, such as: maintain professional standards and treat others with respect. Other aspects of the Guide are more specific: always using your name when giving medical advice online, keeping your personal and professional use of social media separate and avoiding communicating with patients through personal social networking sites. It is also a requirement that you should be satisfied that any medical advice that you provide online is accurate and valid. The Guide also suggests that you adopt 'conservative privacy settings' so as to minimise, so far as possible, the amount of people who can access your social media accounts. The big health warning with all social media accounts is that you cannot control what others do with a comment you make online.

In 2014 the Medical Council commissioned a survey[3] of 1,000 people in advance of its introduction of the 2016 Guide. It will not come as a surprise to many to learn that 87% of the 1,000 people surveyed strongly agreed that a doctor should never share patient information through social media. Perhaps the more interesting response was to the statement:

"If my Doctor posted personal information on social media, it would make me think differently about his/her professionalism."

66% of the respondents strongly agreed, with this figure increasing to 76% if those who agreed slightly are included. The responses were then broken down into age categories with 64% of each of the 16-24, 25-34 and 35-49 year age groups agreeing with the statement. Those rates increased to 71% and 70% for the 50-64 and 65+ age groups respectively. It would seem from the survey that an overwhelming majority of even the most prolific social media using age groups are not only unenthusiastic about their doctor sharing their own personal information online but would question their doctor's professionalism as a result.

DEVELOPING A SOCIAL MEDIA POLICY

If your practice has a social media account, then a policy should be developed to ensure that it is managed and maintained appropriately. The policy should cover who has access to the account, who can post material on the account and the type of material which can be posted on the account. It should also include a provision regarding how often material posted to the site should be reviewed, and by whom, to ensure that any historical advice on the account is still accurate and up to date, which is a requirement of the Medical Council Guidelines.

It would also be advisable to include a disclaimer on any website or social media account that you maintain which states that any information posted is not considered to be medical advice and should not be considered medical advice and that it is not intended to replace contacting your GP about any concerns. It should also state, where appropriate, that the sharing of any articles or posts by others should not be considered an endorsement of their contents.

DO'S and DON'TS

There are many positives to using social media. For personal use, it can be a great way of keeping in touch with family and friends as well as those with shared hobbies or interests. As a medical professional, social media can be used to raise awareness and promote public health in a fun or creative way. It can also be a good means of keeping up to date on recent developments within your special areas of interest by following universities, medical journals, other doctors and researchers. The issues generally arise when you start to post your own comments, repost the comments of others or engage directly with other social media users.

You can minimise your risk and enjoy your time on social media by considering the following:

DO

1. Keep your professional and personal social media accounts entirely separate;
2. Ensure your social media accounts have the most restricted privacy settings;
3. Ensure that any information you post online is accurate and valid;
4. Add a visible and obvious disclaimer to your social media accounts;
5. Develop a social media policy for your practice;
6. Include your name on any comment / post where you are giving medical advice online;
7. Remember that no matter what privacy settings you have, other people can still share and circulate your comments and that this will be outside your control;
8. Declare any conflicts of interest.

DON'T

1. Share patient information via social media platforms;
2. Post any information which could potentially identify a patient;
3. Engage directly with patients via social media platforms;
4. Accept friend/connection requests from or make friend/connection requests to patients;
5. Share any personal information on your practice accounts;
6. Share information which you know to be incorrect or which is likely to cause confusion to your patients/members of the public;
7. Forget that you cannot ensure the complete privacy of anything posted on a social media account.

DOCTORS ON THE RECEIVING END OF SOCIAL MEDIA

While most of the focus has been on what doctors should and should not do when using social media, it is important to consider what you can do if you or your practice is the subject of defamatory comments posted online.

Generally, it is advisable not to engage directly with the person who has posted such defamatory material via social media. You should contact Medisec for direct advice on your specific situation. Bear in mind that any correspondence you send to someone who you believe has defamed you may be posted online by them so remain professional and courteous. Often, the person who has posted the defamatory comment is not aware of the legal consequences of their comment and, if they fail to remove the comment upon request, an appropriate warning letter from your solicitor will often bring an end to the matter. Should that fail, it may be necessary to institute defamation proceedings and obtain a Court order that the defamatory comment be removed.

Unpleasant though it is to be the subject of comments online, the comments must be defamatory of you, rather than just unflattering, to give rise to a cause of action.

[1]July 2018
[2]Section 6, Defamation Act 2009
[3]https://www.medicalcouncil.ie/News-and-Publications/Reports/Survey-of-Public-Attitudes-to-Doctors-Professionalsim.pdf

ICGP QUALITY & SAFETY AWARDS

SUPPORTED BY MEDISEC

Medisec are proud to sponsor the annual ICGP Quality and Safety Award which is a very important initiative in promoting patient safety and quality of care in General Practice. We are keen to ensure that the ideas and knowledge are shared for the benefit of our membership. We are delighted to feature contributions from the finalists and overall prize winner over the following three pages.

ATRIAL FIBRILLATION AND STROKE - DR DIARMUID QUINLAN, WINNING ENTRY

Atrial Fibrillation(AF) is common, affecting 1.9% adults: doubling mortality, increasing stroke-risk fivefold.[1]
Stroke is Ireland's third killer after heart disease/cancer.

AF causes 20-30% of strokes, which are frequently severe/fatal.[2] Opportunistic screening increases AF detection, yet much AF remains undiagnosed.[3]

ABCD of AF-Stroke Prevention is a patient-centred sustainable approach to reduce frequency and severity of AF-Stroke. This initiative harnesses existing GP skills, facilitating dissemination. This resembles the London initiative: "AF Toolkit: Detect, Protect, Perfect".[7]

We integrated patient AF literacy and AF screening with optimal OAC to develop the "ABCD of AF-Stroke Prevention".

A: Awareness (Patient AF health-literacy)
B: Baseline ECG
C: Create AF register
D: Decision support tool, to optimise OAC.[5]

ABCD of AF-Stroke Prevention aims to:

1. Improve patient health literacy (stroke recognition)
2. Screen and diagnose "Silent" AF
3. Optimise OAC

A: AWARENESS:

We carried out an assessment of AF-Stroke health literacy by surveying 40 consecutive adults and just 23% correctly identified all 4 components of Act-FAST (Face-droop, Arm-weak, Slurred-Speech, Time-to-dial 999).

On discovering this, our practice response was to:

- Introduce simultaneous AF screening and brief education, using Irish Heart Foundation "Act-FAST" patient information cards, which requires 2-3 minutes per patient. The AF screening tool we used, "AliveCor-KardiaMobile" cost €100.
- Highlight "Act-FAST" on practice website and waiting room TV.
- Published Stroke-AF "Act-FAST" article in town newsletter.

We circulated a patient postal questionnaire 2-4weeks after individual education and 100% correctly identified all 4 components of "Act-FAST".

B: BASELINE

Single lead ECG: November 2014-March 2018 (with 12 lead-ECG verification AF)

C: CREATE AF REGISTER:

NOAC/Warfarin: medication search (65 AF/7010 adults, March 2018)
Age 50-59y 60-69y 70-79y 80y+
AF detected/Patient no. 6/998 18/464 21/250 20/95
AF % of age group 0.6% 3.9% 8.4% 21%

D: DECISION SUPPORT TOOL:

OAC in AF is complex,2 The "Keele Anticoagulation Therapy Decision-Support-Tool Prevention of AF Stroke 5 is NICE validated, enabling early optimal, validated OAC initiation by GP.

62/65 patients taking NOAC, just 3/65 patients taking warfarin (March 2018)

SUMMARY:

Patient AF health-literacy, AF diagnosis and OAC are currently suboptimal. This high-tech, low cost, GP initiative, enhanced:

1. Patient AF health-literacy improved from 23% to 100%.
2. Increased AF diagnosis: (38 in 2014, 65 by March 2018)
3. Targeted screening of >75y commenced.
4. Supports OAC initiation by GP: "Don't wait: Anticoagulate"
5. Supports optimal OAC by GP: 62/65 patients taking NOAC.
6. Some patients had normal screening ECG in medical record, subsequently diagnosed with AF, changing "New-AF" management(cardioversion).

References available on request.

TOWARDS SAFER LONGITUDINAL PRESCRIBING

FINALIST
Dr Luke Sheeran-Purcell, (Intern), Dr Stella Burska (GP Registrar) and Dr Phillip Sheeran-Purcell (GP Principal)

OUR IDEA IS AN ATTEMPT TO MAKE ONGOING SO-CALLED 'LONGITUDINAL' PRESCRIBING SAFER AND LESS TIME CONSUMING. WE HAD NOTED THE NUMBER OF CALLS NEEDED TO HOSPITALS TO CLARIFY MISSING ITEMS ON DISCHARGE PRESCRIPTIONS: WERE THEY STOPPED OR OMITTED? EQUALLY IN OUR OWN PRESCRIBING WE FREQUENTLY RECEIVE CALLS FROM PHARMACISTS ASKING THE SAME THING: DID YOU MEAN TO STOP OR CHANGE A PARTICULAR DRUG?

It is regrettable that there is no effective way of noting this in our practice software - you can of course detail the change in the clinical note, but this is a very cumbersome way of finding a change in drug regime when checking back later.

Using the administration function of our software we added custom drug instructions as short cuts as follows:

Shortcut 'NBN': e.g.: script might read:	appears on prescription as: NB NEW "Amlodipine 5mg i daily NB NEW"
Shortcut 'NBC': e.g.: script might read:	NB CHANGED "Bisoprolol 1.25mg daily NB CHANGED"
Shortcut 'STO': e.g.: script might read:	THIS DRUG STOPPED AS OF NOW "Atorvastatin THIS DRUG STOPPED AS OF NOW"

We committed to always including this extra information on any prescription that had a change.

The only caveat is to make sure to set it for 1 repeat only so that you can remove the note from subsequent issues (unless of course there is further change).

The effect of this is:

1: to find a change in a drug (start, stop or alteration in dose) you can quickly check back through the 'prescription printed' in your software and find the exact date and then go to the relevant clinical note,

2: other staff members in the practice and the community pharmacy and indeed the patient themselves can clearly see that a deliberate change has been made and thus avoid phone-calls and delays.

3: Finally it serves as a 'failsafe' in that, if you change a drug without flagging this, the pharmacist or patient has an opportunity to clarify this thus improving the overall safety of your prescribing.

A survey of the local pharmacies strongly endorsed this as a helpful safety and time-saving measure.

We were delighted and honoured to be placed second in this national competition and found the process very helpful in our ongoing quality improvement efforts.

TOTAL TESTING PROCESS

FINALIST
Dr Denis O'Donovan

Total Testing Process (TTP) describes the complex pathway from the decision to perform a blood test to the communication of the result to the patient. [1] [2]

TTP errors in primary care settings are well described [3-5]. I chose to audit aspects of TTP in my 3rd year of GP Training. The audit was performed in Charleville Family Practice, Co. Cork.

LINNEAUS Euro PC (Learning from International Networks about Errors and Understanding Safety in Primary Care), a collaborative group funded by the European Union, published the first set of recommendations to help GPs create systems for the oversight of blood testing.[6]

Four domains relevant to established hazards in UK and Irish practice were audited.[3] These were, in summary, that:

1. Blood tests were accurately documented in the clinical record (domain C9)
2. A process exists which ensures every returned result can be matched to a test request (domain E5)
3. A protocol is in place for dealing with multiple test results returned at different times (domain H11)
4. There is a standardized process for reviewing non urgent results within clinically appropriate timescales (domain H8)[6]

Audit data were extracted using CompleteGP software. Cycle 1 took place in Oct 2016. This was followed by protocol driven change of practice and cycle 2 was completed in March 2017. 100 patient charts were audited in both cycles. A formal practice protocol was created after cycle 1 standardizing the recording of, and commenting on, blood tests. It was decided that all non-urgent results would be reviewed and documented after 10 days.

DATA MEASURED

1. Whether documentation of blood tests performed was exact, not exact or not documented
2. Whether all results received were documented as reviewed
3. How many days elapsed between phlebotomy and documentation of review in the clinical record

RESULTS

1. Exact documentation of blood tests performed increased from 4% to 78%. The error of non-documentation of a blood test being performed reduced from 14% to 4%.
2. Documentation of a review of blood test results in the patient's chart increased from 44% to 80%.
3. There was no change in average time from phlebotomy to recording of reviews in clinical records.

OTHER IMPROVEMENTS REPORTED BY STAFF

- GPs reported improvements in their psychological well being knowing that they had to "close the loop" in all blood tests performed.
- GPs reported saving time by not having to "dip in and out" of results to check if all tests for a particular patient had returned.
- Administrative staff reported an increased sense of control when patients rang enquiring of their results due to the existence of a protocol and timeframes.

This was a simple and sustainable change of practice which lead to a significant reduction in the hazards surrounding the blood testing process.

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RED ALERT
Please See Again!

The hazards of PSA screening in General Practice

Every week in the Medisec offices, we receive a query, complaint or potential claim regarding some aspect of PSA (prostate specific antigen) screening and testing. The updated 2018 NCCP/HSE referral guidelines have recently been published, and provide very firm and easy to follow guidance for management of prostate screening and results[1]. General Practitioners all over the country seem to be comfortable with the guidance, and referrals are reasonably trouble free, notwithstanding waiting lists around the country.

Follow Up

The problems we see are more to do with the *follow up* of the PSA results. Sometimes a PSA test will be thrown in with a lipid screen or simple FBC on the request of the patient or as an add-on by the GP. As a result, the PSA may not be recognised as a principal test. Sometimes the other bloods which were the main reason for the phlebotomy encounter will return before the PSA, the patient calls for the results and is told everything is fine. Then the PSA result trickles in. It may be slightly elevated but there is a note in the records to indicate that 'test results were communicated to patient'.

The patient may not have another PSA test for a few years, and if by then it is significantly elevated, that's where the difficulty lies.

Not Routine

The 2018 NCCP 'Prostate Cancer GP Referral Guideline' recommends that a PSA test should not be considered a routine test and should only be measured following informed and shared decision making between the patient and their GP.

This can pose a difficulty when the patient asks the practice nurse to 'just check for that prostate test as well'. The limitations of the screening should be explained in detail to the patient.

New age-related PSA limits		
40-49 yrs	< 2	ng/mL
50-59 yrs	< 3	ng/mL
60-69 yrs	< 4	ng/mL
>70 yrs	< 5	ng/mL

DRE

The new guidelines do indicate that if a PSA is being undertaken, then a DRE (Digital Rectal Examination should be performed as well as part of the screening protocol.

RED ALERT – beware transfer from secondary care
It can happen that a patient is noted during a hospital admission to have an elevated or abnormal blood result. This may be indicated on the hospital discharge summary with instructions for the GP to 'follow up'.

When initiated by the hospital, this information can be easily overlooked, and the discharge summary with the relevant PSA information inadvertently scanned into the patient's file without further action.

Follow Up Protocol

Even if the patient has been informed, they may not fully comprehend the relevance or importance of such follow up. Consider tasking your administration staff or practice nurse to come up with a good protocol or management plan for these cases. If your software system won't allow it, or is too complicated, do not underestimate the power of a simple diary or notebook to alert the practice nurse of an overdue test or recall.

Marginal results

Marginally elevated PSA levels are a common bugbear, but nevertheless must be followed up in a timely manner to avoid missing a significant prostate cancer. Sadly, this has come to the attention of Medisec on more than one occasion.

Audit

If wondering about your Audit for the year, consider pulling all the PSA results from a designated time period and examine the efficiency of your practice in following them up.

[1]National Prostate Cancer GP Referral Guidelines 2018 https://www.hse.ie/eng/services/list/5/cancer/profinfo/resources/gpreferrals/nccp-prostate-cancer-gp-referral-guideline.pdf

THE REQUIREMENT TO KEEP UP TO DATE AND THE LAW

By Arthur Cush, BL

INTRODUCTION

All medical practitioners are required to keep their individual medical knowledge and skills up to date. There are two aspects to this obligation. The first is the duty imposed by Part 11 of the Medical Practitioners Act 2007 and the regulations made under that Act. A breach of these requirements can result in a practitioner being disciplined by the Medical Council. The second aspect is the duty imposed by the law of negligence. A failure to keep up to date will result in a finding of negligence against the practitioner if there is a sufficient causal link between the specific failure and the harm suffered by the patient.

THE MEDICAL PRACTITIONERS ACT 2007

The requirement to keep up to date extends to all doctors whose names are entered in the General and Specialist divisions of the Register of Medical Practitioners. Section 94 of the Act requires that a practitioner "shall maintain the practitioner's professional competence on an ongoing basis pursuant to a professional competence scheme applicable to that practitioner".

Professional Competence Schemes (PCS) are the formal structures that the Medical Council uses to ensure that doctors maintain ongoing professional competence. The schemes are operated by the postgraduate training bodies. Practitioners are required to enroll in the PCS that is most relevant to their education, training and current practice regardless of whether they attended that particular institution.

Practitioners are required to participate in fifty hours of Continuous Professional Development (CPD) activities per year whether they are in full time or part time medical practice. The Medical Council provides that this CPD activity should be broken down into internal (maintenance of knowledge and skills), external (practice evaluation and development) and personal learning and research/teaching categories. In addition, practitioners are required to take part in at least one clinical audit exercise each year.

A practitioner who fails or refuses to meet their CPD requirements will be the subject of a complaint to the Medical Council's Preliminary Proceedings Committee (PPC). Once the complaint has been filed the case officer handling the complaint will allow the practitioner a period of time in which to provide any information or explanation which may be relevant. The PPC may also require the practitioner to provide additional information or documentation. The PPC may decide to refer the complaint to the relevant Professional Competence Schemes or alternatively may resolve the complaint by informal means such as an undertaking by the practitioner to meet the CPD requirements.

The PPC may require a practitioner to provide an extensive assessment of practice. This may lead to a medical practitioner being obliged to participate in a performance assessment and the practitioner will be responsible for all costs associated with any assessment.

The PPC may refer a complaint to the Fitness to Practise Committee which has the power to request the practitioner to undertake to meet these statutory requirements and not to repeat the conduct giving rise to the complaint. A practitioner may also be asked to consent to being censured by the Medical Council. The Medical Council also has the power to apply any of the following sanctions contained in section 71 of the Act:

a) An advice, or admonishment or censure in writing;

b) A censure in writing and a fine not exceeding €5,000.00;

c) The attachment of conditions to the practitioner's registration, including restrictions on the practice of medicine that may be engaged in by the practitioner;

d) The transfer of the practitioner's registration to another division of the register;

e) The suspension of the practitioner's registration for a specified period;

f) The cancellation of the practitioner's registration; and

g) The prohibition from applying for a specified period for the restoration of the practitioner's registration.

LIABILITY IN NEGLIGENCE

A practitioner's potential liability for negligently failing to keep up to date exists independently of the requirements of the Act and predates its enactment. Although compliance with the Act will protect a practitioner in many cases, it cannot be said that a practitioner who complies with the requirements of the Act has removed the possibility of a finding in negligence.

For example, practitioners are required to enroll themselves in the PCS most relevant to their area of practice. If a practitioner engages in an area of practice, even rarely, in which they have not received CPD training, then that practitioner is under an independent common law duty to keep reasonably up to date in that area.

It is important to note that the duty applies to both individual practitioners and to institutions. In the case of *H. M. v Health Service Executive*[1], Judge Charlton held that:

> *"The responsibility, in that regard, attaches to the defendant hospital in the management and organisation of a busy maternity unit. Ordinary care demands that such a unit be kept reasonably up to date in important thinking in medical science".*

Medical negligence cases are by their nature uniquely fact specific and the duty of each practitioner will depend on their own specialisation and circumstances. As such it is not possible to give definitive universal guidance. In the H.M case, Judge Charlton gave fact specific guidance as to why, in this particular case, the failure to keep up to date had contributed to a finding of negligence:

> *"Since these guidelines were extremely important, involving a commonly occurring injury, and making practical and difficult to dispute suggestions, they should have been implemented. At the very least the hospital should have ensured that they were discussed between the hospital staff or the subject of a circular by electronic or paper means".*

Despite the disparate nature of these types of cases, a number of general principles can be distilled;

- A practitioner is only required to keep up to date in the area of his or her own sphere of practice so that they will be able to deliver *"a good standard of care to the patient"*. See Hughes v Staunton[2].

- A practitioner is not required to read every article appearing in the current medical press but the time may come when a new recommendation may be so well proved and so well known and accepted, that a failure to adopt it would amount to negligence. See Crawford v Board of Governors of Charing Cross Hospital[3].

- The Courts accept that different methods of keeping up to date are used and it is acceptable that individual preferences differ. For example, one practitioner may prefer to read textbooks, another journals and yet another may prefer to seek the advice of other practitioners. Where no one text can be agreed as authoritative, a practitioner is not expected to read all of the information available. See Bellarby v Worthing and Southlands Hospitals NHS Trust[4].

- A Court will consider the state of up to date medical knowledge at the time the incident occurred. However, once an incident has occurred as a result of an out of date practice, from that point onwards a practitioner or institution will be negligent if they fail to implement that specific up to date practice. See Roe v Ministry of Health[5].

CONCLUSION

The Act provides an effective and enforceable formal scheme for the professional development of medical practitioners. In the vast majority of circumstances practitioners who fulfill their obligations under the Act will have protected themselves from a finding in negligence. However, practitioners should be conscious that compliance with the Act alone is not sufficient in all cases. In a time where practitioners have access to instant communication with each other and vast online resources of up to date accredited information, Courts will sometimes require practitioners to take steps beyond those required by the Act.

[1][2011 IEHC 339]. [2](12 February 1990) HC Lynch J. 3(1953) CA Denning J. [4][2005 EWHC 2089 QB]. [5][1954] 2 All ER 131

OUT & ABOUT

Dr Mary Davin Power, Joe Schmidt and Dr Myra Cullinane

Coroner's Court

Medisec coordinated the Coroner's Court, Mock Inquest at the ICGP's Annual Conference on 25 and 26 May. We are grateful to Dr Myra Cullinane, Dublin City Coroner, Roger Murray, Partner of Callan Tansey Solicitors, Michael Counihane SC, Dr Mel Bates, GP and Dr John Cox, GP for their assistance and participation.

We were delighted to present the inaugural Quality and Safety in Practice GP Trainee Award at the GP Trainee Conference in Galway. We hope to share extracts from the finalists' entries in the next edition of On Call.


Brian Osbourne, Ruth Shipsey, Brian Prendiville, David Brennan, Fareeda Borhan


Aoife O'Higgins and Dr James McGrath


Eimear Bourke and Dr Noreen Walsh

Aoife O'Higgins, Aisling Malone and Danielle Gannon

- Ruth Shipsey discussed "Whose report is it anyway?" at the GP Trainers' Conference in Galway on 11 October.
- Dr Mary Davin Power lectured on the ICGP Refresher Course on 18 October 2018
- Ruth Shipsey and Aisling Malone gave presentations on Medico-Legal Challenges and GDPR as part of the ICGP's course of practice staff in the Aishling Hotel on 09 November.
- Aisling Malone presented "A cure for the common complaint?" at the ICPG Winter conference in Athlone on 17 November.
- A five-strong team of solicitors from Medisec travelled to the South Tipperary CME Scheme's to resource its meeting on 13 November with presentations on Trends in Complaints and Claims; Medical Reports; Confidentiality; Medication issues; and Challenging Patients.

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 CME groups and study days. Please contact Ruth Shipsey to request a Medisec speaker.

TOP TIPS

DELAYED SUMMARIES FROM OUT OF HOURS CO-OPS

Medisec receive many requests for assistance where, due to a delay or break in communication the GP was unaware of care given to a patient and therefore did not follow up as would be their normal practice. If your co-op is slow to send information, perhaps a chat with the director regarding prompt communication would be advantageous to all. We understand that on some systems updates from the co-op can be intergrated in to a patient's chart without being read by a GP. All co-op summaries must be read by a GP and actioned where appropriate.

PATIENTS WITH SIMILAR NAMES

This is a constant risk in General Practice. Ensure that there is an obvious alert on the record of a patient where you are aware of another patient with a similar or identical name. This will help prevent inadvertent disclosures and misfiling of results. Now more than ever we need to be mindful of patient confidentiality.

SIGNING PRESCRIPTIONS FROM ABROAD

Many members approach Medisec with advice regarding the transcription of prescriptions from abroad. If you sign it, it is your prescription and you are responsible! Where a patient attends with a request for you to transcribe an unfamiliar or high-risk medication, you are not obliged to perscribe if you feel that the management and monitoring of the patient is outside your area of expertise. Discuss with the patient and offer to arrange referral to a specialist in the specific clinical area involved.

PSA FOLLOW UP

Medisec are aware of more difficulties with PSA follow up than almost all other investigations combined. If a PSA result is borderline, do not dismiss as 'false positive' but ensure repeat and follow up. It is important to emphasise the importance of this to the patient, who may not understand the significance of further monitoring. Pre-PSA counselling should be undertaken so that the patient understands the advantages, limitations and disadvantages of the test. Do yourself and your patients a favour –consider an audit of your PSA results!

METHOTREXATE

A European Literature systematic literature review from 2015 revealed that 47 % of all serious medication errors were caused by seven drugs or drug classes: methotrexate, warfarin, nonsteroidal anti-inflammatory drugs (NSAIDS), digoxin, opioids, acetylic salicylic acid, and beta-blockers. Within that figure, methotrexate stood out as causing 26% of fatal and 11% of non-fatal errors. Look at your methotrexate patient records one more time and ensure that you will not cause a new statistic! Check that all patients on methotrexate are on 2.5 mg tablets, a weekly not daily dose, have routine blood monitoring and are on supplemental folic acid.

SALADs

No, it's not lunchtime yet. These are 'Sound Alike, Look Alike Drugs'. Remain alert to the hazards which include repeat prescribing, drop down menus, handwritten prescriptions and telephone requests for medications. Think 'Eltroxin and Naltrexone'; 'Lamisil and Lamictal'; 'Tramadol and Trazodone'; 'Zolpidem and Zolmitriptan'.

IRISH MEDICAL FOOTBALL TEAM
SPONSORED BY MEDISEC

A team of Irish doctors, sponsored by Medisec, took part in the World Medical Football Championships in Prague this July, an event colloquially known as the Doctors' World Cup.

The competition is over 20 years old, with 22 teams from all over the world striving to take home the title of wold champions.

In unique twist, each team must have two players over 35 and two players over 40 on the field at any time, to encourage participation at all ages. And in case any team considers sneaking in non-medical players, everyone may be quizzed about common medical scenarios on the sidelines.

The Irish team consist of a mix of GPs from all corners of Ireland along with some hospital doctors of all levels.

Sadly, the tournament did not work as planned this year for the Irish – they lost out to eventual winners Great Britain early on, before succumbing to an injury time winner against three time champions Hungary. However Ireland did rack up comfortable victories against lesser lights Lithuania, Canada and South Korea.

The team would like to thank Medisec for their continued support over each of the four years that the Irish have entered the event. They are already looking forward to the 2017 event, which takes place in Cancun, Mexico in July next year.

Any doctors interested in taking part next year, please contact the team organisers via email on irishmedicalfootball@gmail.com.

BEST PRACTICE IN TELEPHONE TRIAGE BY NON-CLINICAL STAFF

A BRIEF GUIDE FOR MEDISEC MEMBERS

Telephone triage by non-clinical administrative staff is a major part of practice workload and can be a source of medico-legal complaints. It is good practice to have a formal policy on how such staff might respond to requests by patients for an emergency or urgent appointment.

Telephone triage by non-clinical administrative staff is a major part of practice workload and can be a source of medico-legal complaints. It is good practice to have a formal policy on how such staff might respond to requests by patients for an emergency or urgent appointment.

The GP Principal or named deputy should communicate this policy to all members of the practice team who are involved in handling such telephone requests, including locums and practice staff who may be working at the practice on a temporary basis. Information on the policy should be available to patients of the practice and other key stakeholders.

We recognise that developing such policies can be challenging, especially in practices with larger teams and given the more sophisticated ways in which patients can interact with the practice. This brief guide is an introduction to the issues to consider in the development and implementation of a 'Practice Policy on Telephone Triage by Non-Clinical Staff'.

A robust policy can assist in giving the authority and the confidence to staff to call an ambulance if necessary in the absence of a clinical member of the team on the premises. In all situations, non-clinical staff should be reassured that immediately referring a call to the GP / practice nurse (for whatever reason) is a reasonable course of action.

1. HOW SOON IS NOW?

When a patient makes contact with the practice requesting an urgent consultation or advice, there can be several categories of response:

- Go directly to A&E
- Call an ambulance
- See doctor next
- Same Day appointment
- Soon appointment – next 2 days
- Routine appointment

2. EMERGENCY / URGENT / ROUTINE – HOW TO DECIDE?

Many algorithms have been developed to help triage patients seeking a same-day "urgent" appointment by telephone or as a walk-in. The suggested Medisec Triage Protocol, while not exhaustive, may help a practice to determine if it should facilitate review that day, advise the patient to attend ED or contact the Ambulance Service (see Appendix[1] below) .

3. PATIENTS NOT CURRENTLY REGISTERED WITH THE PRACTICE

When a patient who is not a member of the practice has an issue requiring an urgent or emergency response, then, as a duty of care now exists, it is essential that the practice provide the appropriate response (e.g. facilitate same-day review, advise to attend A&E or contact an ambulance).

4. SPECIFIC PATIENT GROUPS FOR WHOM SPECIAL ATTENTION MAY BE REQUIRED

Special attention may be required when handling telephone contacts from patient groups at increased risk (e.g. pregnant women, young children, elderly, patients with chronic conditions, patients with intellectual disability, patients who have language difficulties 2). In addition, patients who contact the practice regarding a deterioration in a known problem, should at a minimum speak with the GP / practice nurse and appropriate follow up should be arranged.

5. ACCESS TO CARE

Practices should ensure that they treat all patients equally where access to care is concerned, as practices "should not discriminate against patients or colleagues on any grounds"3. It is important to address with staff the issue of avoiding any possible perception of discrimination against certain groups, families or minorities. In particular those with specific challenges such as methadone patients, homeless patients, patients who are members of minority ethnic communities etc. It is advisable to raise awareness and promote a clear ethical stance in the practice. Some members of staff may not realise that patients can sometimes consider their actions to be discriminatory1 and that this could lead to a Medical Council complaint or an allegation of discrimination.

6. CLINICAL HISTORY TAKING BY ADMINISTRATIVE STAFF

It is essential that administrative staff gather enough information to be in a position to assess the urgency of the patient's request. They can enquire as to 'the nature of the problem', within reason. The type of language and tone used is very important for this type of enquiry.

'What is the matter?' could be construed as inappropriate, whereas 'may I enquire as to the nature of the problem?' offers the patient more leeway to give as much or as little information as they wish. The reception staff should learn to pick up cues regarding at what level the patient feels uncomfortable in sharing information, and a broader question such as 'Do you think this is something which needs immediate attention?' may put more onus on the patient to be reasonable in their request. Non-clinical staff should always be reassured that immediately referring a call to the GP / practice nurse (for whatever reason) is a reasonable course of action.

7. AGGRESSIVE PATIENTS

When dealing with aggressive or difficult patients, it is important to recognise that this can sometimes be as a result of worry or fear over the caller's own or a family member's situation. In such situations, it would be appropriate to pass the call on to the GP / Practice Nurse.

8. NEW AND TEMPORARY ADMINISTRATIVE STAFF

New staff or inexperienced staff will need support and consistent advice while settling in to what is a demanding and difficult job. It is vital that they feel they can approach other members of the practice team for advice. A single explanatory session on their first day will not suffice and they should be given many opportunities to raise questions and queries thereafter. It is also important to realise that experience counts for a lot, and a new receptionist may not recognise the terror of a sick baby or a wheezy teenager.

9. QUALITY ASSURANCE - CRITICAL INCIDENT REVIEW AND CLINICAL AUDIT

The practice policy on telephone triage should include a method for significant incident reporting and recording and be subject to regular audit and quality review.

10. LOGGING SIGNIFICANT CALLS

It can be cumbersome and time consuming to log all calls requesting 'urgent' appointments, but Medisec advises that where any contentious issues arise, you should note a log of the call and a description of the request. Some practices have installed call-recording software which automatically records calls, but patients should be advised that their calls are being recorded and processing and retention should be in accordance with GDPR requirements.

Although telephone triage is used increasingly to manage the workload in general practice, it is actually associated with an increase in the number of primary care contacts in the days after a patient's request for a same-day GP consultation4.

Considering the issues outlined above should help to develop safe and effective systems for dealing with telephone requests for same day appointments.

BEST PRACTICE IN TELEPHONE TRIAGE BY NON-CLINICAL STAFF CHECKLIST

CHECKLIST FOR TELEPHONE TRIAGE

Advise caller to call an ambulance if the patient:

- Is so breathless they have difficulty speaking
- Has severe chest pain
- Has palpitations – especially if feels weak or faint
- Has weakness of any part of the body especially arms or legs
- Is unconsciousness
- Has uncontrollable bleeding
- Has vomited large amounts of blood
- Has collapsed suddenly
- Has or is having a fit or seizure, i.e. lying on the ground and twitching with loss of consciousness
- Has experienced a very severe burn
- Has taken an overdose, poisoning or attempted suicide
- Has a suspected severe allergic reaction
- Is a young child who has suddenly become very unwell for any reason
- Is pregnant and has experienced significant pain / bleeding

Advise caller that patient should attend Emergency Department if the patient:

- Has experienced a head injury – especially if there has been a loss of consciousness, persistent dizziness or vomiting
- Has a broken bone or dislocated joint
- Has got something in their eye that is affecting vision
- Has a sudden change in their mental state or difficulty speaking
- Has sudden changes in vision or loss of vision
- Severe burns but not affecting their ability to attend a&e
- Has severe testicular pain
- Has an unusually severe headache
- Is unable to pass urine
- Is a young child who has become unwell for any reason
- Is pregnant and has experienced reduced movement / pain

Discuss with GP or nurse now if the patient:

- Is experiencing severe abdominal pain
- Is experiencing bleeding that cannot be controlled
- Has had any type of limb injury
- Is experiencing any eye or vision problems
- Is experiencing any mental health problem or extreme anxiety - including suicidal ideation
- Has severe pain
- Has experienced burns/scalds
- Is contacting about an urgent pathology result
- Has persistent vomiting
- Any concern by the caller

Attend practice immediately for assessment if the patient:

- Has developed a sudden severe rash, with no other symptoms
- Is a child or elderly patient who is unwell for any reason
- Has persistent symptoms (>48hrs) such as fever, vomiting, diarrhoea, cough
- Has been vomiting or had diarrhoea for >72 hrs
- Is an infant with a fever
- Is pregnant and is concerned for any reason
- Is experiencing a possible adverse reaction to a medication

Same day appointment if the patient:

- Has a severe eye problem
- Has severe ear pain –
- Has a fever (Adult), but is otherwise well
- Has severe flu-like symptoms
- Is experiencing any problem after a surgical procedure
- Has been recently discharged from hospital
- Has any urinary symptom
- Has a possible wound infection
- Is requesting the morning after pill
- Is experiencing a deterioration of a longstanding condition

Next available appointment if the patient:

- Is requesting a repeat prescription
- Is requesting a STI screen
- Has a longstanding condition which has not recently changed
- Is seeking a ‘general check up’
- Is requesting a routine medical check - Driving licence medical, well woman/well man check, Insurance medical, illness certification
- Is requesting a non-urgent blood test.

References

1. The Equal Status Act, 2000 protects people from discrimination on the grounds of gender, marital or family status, sexual orientation, religious belief, age, disability, race and membership of the Travelling Community. (http://www.irishstatutebook.ie/2000/en/act/pub/0008/index.html)
2. TRIAGE AT RECEPTION - I Want an Appointment Now! (https://medisec.ie/News/A-guide-for-GPs-and-their-staff-on-triage-at-reception)
3. Guide to Professional Conduct and Ethics for Registered Medical Practitioners (8th Ed) In. Dublin Medical Council of Ireland; 2016.
4. Campbell JL, Fletcher E, Britten N, Green C, Holt TA, Lattimer V, Richards DA, Richards SH, Salisbury C, Calitri R et al: Telephone triage for management of same-day consultation requests in general practice (the ESTEEM trial): a cluster-randomised controlled trial and cost-consequence analysis. Lancet 2014, 384(9957):1859-1868.

Patients don’t always appreciate that a missed appointment often represents a missed opportunity for another patient. To encourage your patients to let you know in advance if they no longer need or cannot keep their appointment, you might like to display this poster in your waiting room.

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