MEDISEC ON CALL

Spring Summer 2014

Around the clock support for the Irish GP community

MEDISEC IRELAND

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spring / summer issue 2014

I'm delighted to welcome you to the first issue of On Call from Medisec, a periodical newsletter, which we hope will educate, inform and engage you. Inside you will find ongoing contributions from a range of experts on topics that we believe are at the heart of life for a modern GP.

The articles we publish are based on the wide variety of queries and feedback we receive, giving you an insight into the broad range of subjects that concern our ever-growing community of members.

Our legal panel has submitted articles, which are both topical and practical. They have kindly agreed to contribute to future editions and we would welcome suggestions on topics you would like discussed.

We have assembled an authoritative and respected GP Advisory Panel to grapple with the many clinical issues that are currently challenging our members and they will continue to analyse new themes as they arise. I am extremely grateful to Dr Mary Gray for her article on the opposite page in which she gives you some insight into the workings of the Panel.

If you would like us to expand on any of the points raised in On Call or have any general queries concerning your membership, please do not hesitate to get in touch.

Yours,

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CEO Medisec

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ASKING THE EXPERTS

GP Advisory Panel Chair Dr. Mary Gray discusses the Panel's role

PUTTING THE PANEL TOGETHER

When discussing matters of the utmost importance for Medisec members, establishing a panel of experts to assist on clinical as well as medico-legal issues was vital. With that in mind, a panel of five leading GP figures was established.

A UNIQUE KIND OF SPECIALISM

The personnel at Medisec are highly qualified and equipped to advise GPs on the majority of queries that arise on a daily basis. Should issues be more unusual or clinically complex, Medisec, or their legal advisors, will refer the query, or aspects of the query, to the GP Advisory Panel members for their opinions. Panel members will respond to Medisec quickly in order to ensure a swift reply to the member. Sometimes opinions are needed rapidly – a GP may ring for on the spot advice for an acute or evolving problem. At other times, the complexities of particular issues require more in-depth consideration by all involved.

AN EVER-EVOLVING RESOURCE

The Advisory Panel are regularly involved in updating Medisec's online frame of reference document with its A-Z of medico-legal advice, which arises from member queries. They also counsel on relevant Medisec publications and initiatives. In particular, the Panel assist in identifying what is considered 'normal practice', which is the working definition of what professional indemnity covers. This is necessarily broad.

Medisec is mindful not to incur excessive costs for members when considering peripheral procedures that could attract too high a litigation risk. Medisec is an independent 'not for profit' company owned by its GP members. 'What is best for the membership' is our guiding principle and the ever-developing role of the Irish GP makes for constant evolution.

KNOWLEDGEABLE, CONFIDENTIAL & RESPONSIVE

While the Panel meets formally every quarter, it is responsive as needed on a daily basis. Individual GP queries that are forwarded by Medisec to the Panel are identified as case numbers to maintain confidentiality. Examples of the range of topics include, but are by no means limited to:

- Clinical issues arising in prescribing for minors and the issue of consent and refusal by minors in relation to health and records.
- Complex end-of-life care issues including healthcare decisions, consent and treatment limitations.
- Assessing the capacity of older or debilitated patients to make decisions concerning wills or enduring powers of attorney.
- The complex range of GP difficulties dealing with secondary and other care services.
- Helping GPs to identify their normal roles and responsibilities at a time when expectations of the GP are continually increasing.

We also assist Medisec with complaints against GPs that involve the Medical Council, the HSE or other parties and are pleased that the work Medisec do in assisting GPs is acknowledged as being of a particularly high standard. We are involved in Medisec's risk management initiatives and education drives – areas that are increasingly challenging in general practice. We also alert the company to significant issues arising in general practice that could impact on risk and exposure for GPs.

It is a pleasure to be involved with a company of the calibre of Medisec and we look forward to continuing to provide our assistance to the best of our abilities.

Dr Mary Gray (Chair) MB, BCh, BAO, DCH, DO, FPC, Dip Derm., Dip Health Law and Ethics.

GP ADVISORY PANEL
(From left to right):
Dr Mary Gray,
Professor Walter Cullen,
Dr Mary Davin–Power,
Dr Claire McNicholas &
Dr Ray Walley

THE RIGHT RESPONSE

George O'Connor,
O'CONNOR Solicitors

How to deal with a complaint from the Medical Council

For any GP, a complaint from the Medical Council can be very stressful. Whether the basis for a complaint is something serious or seemingly trivial, your immediate response is extremely important. With that in mind George O'Connor of Panel firm O'Connor Solicitors has highlighted some of the practical steps you should take on receipt of any such communication.

In Ireland, complaints about individual doctors are investigated by the Medical Council. Professional misconduct, poor professional performance and a relevant medical disability are the most common grounds on which complaints are made.

Any individual may make a complaint about a doctor to the Medical Council, including:

- Patients
- Members of the public
- Employers
- Other healthcare staff
- The Medical Council itself

MAKE MEDISEC YOUR FIRST PORT OF CALL

If you receive correspondence from the Medical Council with a complaint you should immediately send it to Medisec seeking assistance. If the complaint relates to a "relevant medical disability", it is vital that you refer this to Medisec seeking advice without delay, as it may be possible to have health related issues referred to the Health Committee of the Medical Council. No matter how trivial, inconsequential or absurd a complaint may appear it is essential that you send it to Medisec, immediately.

A FEW "DON'TS" TO KEEP IN MIND

There are certain things you need to remember to avoid under any circumstances:

- Don't ignore a Medical Council complaint. It will not "go-away".
- Don't criticise or abuse the Medical Council and/or its Case Officers on receipt of a complaint. They are doing the job as required by the Medical Practitioners Act 2007.
- Don't contact a patient, or person, making a complaint to persuade them to withdraw the complaint. To do so may be interpreted as an attempt to intimidate or coerce a complainant, giving rise to further allegations of professional misconduct.
- Don't fail to notify Medisec in timely fashion as failure to do so may invalidate discretionary assistance, which Medisec may otherwise provide.

IN THE AFTERMATH OF A COMPLAINT

When you receive first notification of a Medical Council complaint you will be advised that you have 14 days in which to provide information for the assistance of the Preliminary Proceedings Committee (PPC), should you wish to. While no issue arises if you do not respond at this stage, it may be advisable to do so, as this may ensure that the process will move more swiftly.

It is important to provide Medisec with as complete and comprehensive a response to the complaint as possible, with all the relevant supporting documents, including clinical notes.

When the PPC consider the complaint, and, if available, your initial observations, the PPC will instruct the Case Officer to send your reply to the complainant, to seek the complainant's response to your observations.

The Case Officer will then prepare a "Case Report" and send this to you, seeking your response within 21 days. It is important to send this letter, Case Report and documents to Medisec immediately as it may be important to respond to the Case Report.

In some cases, the Case Report will include the Case Officers recommendations for further investigations. The PPC is not obliged to follow these recommendations and may direct further or additional investigations.

Where the PPC direct further investigations, these may include:

- Interviewing and taking statements from witnesses.
- Obtaining medical and other records.
- Seeking an expert report.

This part of the process typically takes three to six months, but may take longer.

At each stage it is vital for your own protection that Medisec is provided with all correspondence from the Medical Council and your observations or views without delay, before you reply to the Medical Council.

Whether the PPC decides to either refer a complaint to the Fitness to Practice Committee or not, the PPC is required to give reasons for this decision. If the PPC decides that there is a prima facie case for further action in relation to the complaint, they will refer the complaint to the Fitness to Practice Committee.

If a complaint is referred to the Fitness to Practice Committee, Medisec will provide specific advice as to what steps to take throughout any Fitness to Practice Committee Inquiry process.

In rare cases where there is a concern that the actions of a doctor represents a threat to the public, Section 60 of the Medical Practitioners Act 2007 provides that the Medical Council may make an ex-parte Court application for an order suspending registration of that doctor, until further steps are taken. If you receive notice of such an application, you should contact Medisec immediately, as you may have an opportunity to show the Medical Council that such an order is unnecessary or to ensure that other action is taken, such as referral to the Health Committee, if appropriate.

YOU'RE HIRED

Ten top tips to better recruitment

Deirdre Malone,
Comyn Kelleher Tobin

"If you think hiring professionals is expensive, try hiring amateurs"
Red Adair

Although oil well fire fighter Red Adair never ran a busy surgery, his saying still rings true today for the modern Irish GP when it comes to hiring staff. It's important to surround yourself with the right people. To find the right people, you need to know how to look for them. A secretary you hire to fill a gap may end up supporting you through thirty years of ups and downs. It's important, therefore, to ensure you always select the correct staff for every role you are trying to fill and in this article Deirdre Malone of Panel firm Comyn Kelleher Tobin gives you some useful tips.

Recruiting practice staff brings its own difficulties with confidentiality being a huge concern. With all this in mind, here are her top 10 tips to avoid litigation when a GP decides not to use an agency and to go it alone to recruit directly:

TIP 1 – GET THE ADVERTISEMENT RIGHT

When advertising a position, identify the job title and suitable applicants clearly.

Equality legislation provides candidates with a right to equal treatment when applying for a job. In particular, single words in an advertisement may be discriminatory exposing a GP to a claim from the Equality Tribunal.

There are nine "discriminatory" grounds in Ireland:

Gender, marital (civil) status, family status, sexual orientation, religion, age, disability, race, and membership of the traveller community.

To avoid litigation, you should avoid the following extreme example:

"GP seeks mature, white, Catholic, married, female receptionist for busy practice in local Parish."

TIP 2 – AVOID CHARGES OF DISCRIMINATION

People have natural prejudices. A GP would have to interview every candidate if this was not the case. The reason for selecting one candidate over another can be as simple as the individual's experience.

Another reason could be if a candidate has a poorly prepared CV or attends the interview in ripped jeans and dirty runners, feel free to "discriminate". If a decision not to recruit is made on the basis of a candidate's attendance in clothes suggestive of religious belief however, it is discriminatory.

TIP 3 – PREPARE INTERVIEW QUESTIONS

Prepare a list of questions in advance of the interview.

An interview often becomes an informal chat. One question leads to another and suddenly an interviewer is asking what happens when the female candidate's young son is sick and needs to stay home from school, so avoid this trap.

TIP 4 – BRING A WITNESS AND TAKE NOTES

It is always best practice to have two people interviewing a candidate. Someone should take notes. They do not need to actively participate in the interview.

The notes taken during all interviews should be retained securely for 12 months. These notes may be helpful in defending any future discrimination claims to the Equality Tribunal.

TIP 5 – DATA PROTECTION

GPs are familiar with their obligation to retain their patients' data securely and keep it up to date. GPs regularly receive requests for copies of medical records from private and public patients under the Data Protection and Freedom of Information legislation respectively.

Similarly, a candidate may request the notes taken during interview under Data Protection legislation. There is a perception of discrimination should any notes or annotation record something potentially discriminatory. For example, writing a candidate's nationality on the top of a CV received automatically gives grounds to an unsuccessful candidate to take a case.

TIP 6 – REFERENCE CHECKING

Limit reference checking to those who are offered the role only. Never make contact with a referee without the consent of the applicant. Ideally, consent should be sought at the interview stage from the candidate. While there is no reason why a telephone reference should not be accepted, best practice is to obtain a written reference.

Garda vetting should also form part of the reference checking process particularly if the surgery or practice's patients include children or vulnerable adults with whom a staff member may have direct contact or unsupervised access. A Garda clearance certificate is not required for administrative staff, as they will not have unsupervised access to children or vulnerable adults. A candidate's written consent is required on the Garda Vetting Application Form. It takes about 6 to 12 weeks to process and this should be done prior to the employee's commencement of employment.

TIP 7 – CONDITIONAL OFFERS

Ensure that it is a pre-condition to any offer of employment that written proof of Professional Indemnity Insurance and registration with the Irish Medical Council or An Bord Altranais, as the case may be, are produced before offering a contract of employment to a doctor or practice nurse.

TIP 8 – WRITTEN CONTRACT

Not only is it helpful in the event of a dispute, but it is also required by law that employees are provided with a letter setting out their terms and conditions of employment within 8 weeks of their start date.

All contracts should include a probationary period and strong confidentiality clause that continues after termination of employment.

TIP 9 – HAND BOOK

Employers are required to have policies in place to deal with grievances, disciplinary issues and bullying and harassment in the workplace at a minimum. This should take the form of a handbook rather than including the policies in the contract to allow the policies to be updated as required.

TIP 10 – KEEP RECORDS SECURELY

Hold onto all applications made and notes taken for a period of 12 months.

The successful candidate's application should be held on file for 6 years following the conclusion of their employment.

Finally, employ experience and trust your instinct.

A practical checklist for recruiting a locum:

Any GP employing a locum must ensure that the safety and welfare of patients is protected during their absence. The GP must ensure that the locum doctor is appropriately qualified, registered and in good standing with the Medical Council. As far as possible, patients should be told in advance about the temporary arrangements that will be in place during the GP's absence. This is a list of the checks and enquiries recommended before a locum commences work in a practice.

- Inspect the locum's Professional Indemnity Insurance and confirm that indemnity cover is adequate for GP locums to cover the care of patients. (Please note that the current standard Supplementary Indemnity Cover for GP trainees with some defence bodies does not cover locum GP work.)
- Check Medical Council Registration – this can be done very easily from the Medical Council website, www.medicalcouncil.ie
- Confirm that the locum is suitably qualified for GP work.
- Conduct reference checks - a telephone reference may be more practical than a written reference although, where possible, the latter should be sought.
- Agencies placing locums do a Garda clearance check on all new locums and the GP should seek a copy of the clearance certificate. If recruiting directly, it is advisable that such checks should be carried out by the GP.
- GPs need to ensure continuity of care for patients and must ensure that the locum is trained on the practice systems, including record keeping, referrals and test systems, protocols in emergencies etc.
- The GP must instruct the locum to accurately record all details of clinical care provided by the locum and dated in the patient's notes and ensure such details are made available to the GP without delay.
- There should be a handover or debriefing on the GP's return and the GP should review the patient files assessed by the locum.
- Details of the locum's attendance at the practice including the locum's address, Medical Council registration, PI cover, Garda clearance certificate, references and sample signature should be kept on file.

Kate McMahon,
Kate McMahon & Associates, February 2014

WORKING IN A VACUUM

The perils of out of hours services

As a GP, there are any number of circumstances under which you may find yourself working "out of hours". Kate McMahon of Panel firm McMahon & Associates Solicitors, analyses the risks pertinent to GPs working "on call".

Medisec, working hand in hand with Allianz and our Panel Solitictors, believe that when a claim is made against a member it is necessary not only to provide legal assistance and advice to the member in dealing with that claim – it is also mandated that we analyse why the incident occurred and how a similar occurrence may be avoided.

Such an analysis has shown that there are a disproportionate number of claims involving Medisec members who participate in out of hours services.

Doctors-on-call services operate throughout the country and provide a vital service to patients who require care when their own doctor's surgery is closed, either in the evening or over the course of weekends or bank holidays.

There are a number of obvious reasons why the services provided by the out of hours services are more likely to lead to a claim against a member than services provided to the patient in a GP's own practice. These include the following features:

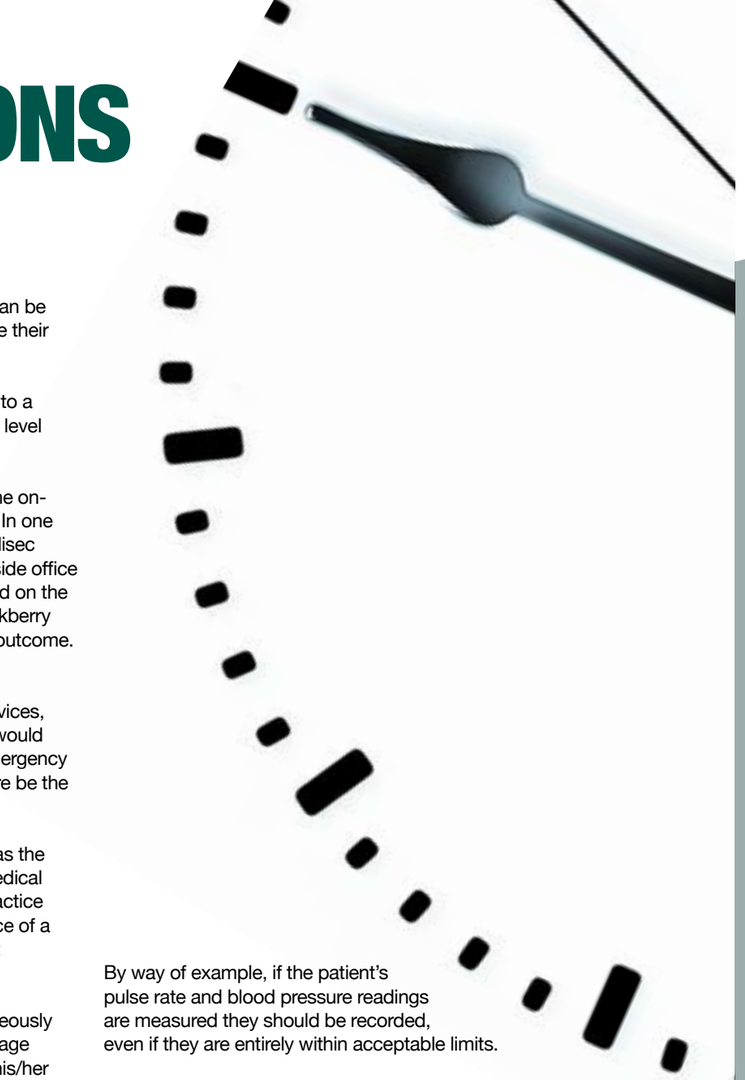
1 A patient who calls a doctor out of hours is doing so as they are suffering from a non-routine illness that cannot wait until their own doctor's surgery reopens. There is also the possibility that they are too ill to travel to their GP. As such, they are potentially suffering from a serious medical condition.

2 The patient is probably not known personally to the doctor-on-call and hence the doctor has no baseline to assist their clinical judgement. By way of example, doctors will know which of their patients has a high pain threshold and rarely complains. If such a patient presents to the surgery complaining, for example, of a very severe headache, then that is likely to act as a 'red flag' to the doctor who will immediately consider that there may be an underlying sinister pathology.

On the other hand, if a patient who is completely unfamiliar to the doctor complains of a similar symptom, the doctor may not be as alarmed as he would not have had any previous personal experience of the patient and would therefore not be aware that it was out of character for this patient to complain.

3 The doctor is entirely reliant on the patient's (or their family's) account of the patient's clinical history and details of any medication they are taking, as in most cases the doctor has no access to the patient's medical records.

PRECAUTIONS
for GPs on call



We believe there are a number of measures, which can be taken by GPs participating in such services to reduce their risk of being implicated in a claim:

i. The telephone call in the first instance should be to a trained receptionist who should at least be at the level that a GP would employ in his/her own surgery.

ii. Best practice dictates that all incoming calls to the on-call-service are referred to a trained triage nurse. In one case, which we have handled on behalf of a Medisec member, there was no triage nurse available outside office hours; there was simply a telephonist who passed on the details to the doctor-on-call via the doctor's Blackberry device. This, in itself, poses a risk of an adverse outcome.

Whilst the out-of-hours doctor services is not an alternative to a patient accessing emergency services, the reality is that many patients who are quite ill would be reluctant to face queuing in an Accident & Emergency Department and their first port of call will therefore be the on-call-services.

Neither a telephonist nor a trained receptionist has the skill or expertise to assess the urgency of any medical situation. It is a basic principle of out of hours practice that priorities are reviewed and hence the absence of a trained triage nurse in the process is a significant risk factor.

Telephone triage should always be contemporaneously documented. The information recorded by the triage nurse is being relied on by the doctor as part of his/her assessment and hence it is essential to establish that that information was actually available to the doctor at the commencement of his/her clinical assessment.

iii. A unique feature of medical negligence cases is that, unlike routine litigation, the issues are invariably determined by the evidence of expert witnesses on both sides, based almost exclusively on the available medical records.

It follows therefore that the quality of the consultation and an expert view as to whether it meets an acceptable standard would be based on what is recorded on the doctor's out of hours consultation sheet.

Whilst we can appreciate that there are enormous time constraints on doctors servicing the out of hours services, insufficient records may lead to a case having to be compromised in the event of an adverse outcome. Short, succinct records are acceptable but it is essential that negative as well as positive findings are recorded.

By way of example, if the patient's pulse rate and blood pressure readings are measured they should be recorded, even if they are entirely within acceptable limits.

Best practice would be for the doctor to have remote access to the computer system at the out of hours service via a tablet or laptop which would enable him to record his notes directly on to the computer system between home visits. Remote access would also allow the doctor to establish that in all cases he has access to the triage nurse's actual note, rather than a transcription of the note taken over the telephone by a third party, such as his driver.

In summary, the out of hours services provide a vital primary care facility for GP patients. It is, however, by its nature, likely to be utilised by patients who need medical assistance urgently and who may have unrealistic expectations of what the service can provide for them. For the reasons outlined above, doctors participating in the services must be fully aware of the exposure that they face.

As a Medisec member, you will be aware that there is a medical advisory service provided which is supported by a 24/7 hotline. Members are actively encouraged to contact Medisec with any queries that they have in relation to participation in out-of-hours services.

CASE BY CASE

Here are two cases that Medisec has advised GPs on recently. All identifying details have been removed and the members have consented to details being made known to facilitate learning

1. A doctor attended an elderly patient as an out-of-hours call. The patient was not previously known to him. She gave a history of a gastrointestinal illness. She reported to him that she had collapsed on a number of occasions, had vomiting and diarrhoea, but the vomiting and diarrhoea had now stopped for 24 hours.

On examination, the doctor found that the patient had a low blood pressure and was clinically dehydrated. He advised her to drink plenty of fluids with Rapolyte powder.

What was not disclosed to the GP was that the patient was on a significantly high dose of a tricyclic antidepressant.

The GP considered admitting the patient to hospital in view of her low blood pressure but ultimately (in the absence of any other symptoms such as chest pain or breathlessness) he arrived at the conclusion that the cause of the earlier collapse was dehydration. Unfortunately, he did not document his exclusion of other causes for the marked low blood pressure.

The patient was found dead by her family approximately eight hours after the examination by the GP. The cause of death was attributed to a recent heart attack with moderate blockages in two of her coronary arteries.

Response: Significantly, the antidepressant was found to be at toxic levels in her bloodstream and in the opinion of the pathologist was, at the very least, a contributory factor in the death of the patient.

Had the GP been made aware of the significantly high dose (and duration) of administration of this medication, he would have been aware of the fact that this medication is known to be cardiotoxic. With this knowledge and with the documented low blood pressure it is almost certain that a referral to hospital would have been made.

Outcome: This case was the subject matter of a complaint to the Fitness to Practice Committee where we represented the General Practitioner over a three-day public hearing. The doctor was exonerated of all charges of professional misconduct and poor professional performance.

2. A 51 year old male patient presented to his GP's surgery with vague upper epigastric pain. There were no additional symptoms, which might have alerted the GP to the possibility that this presentation was an acute coronary syndrome. The pain did not radiate to any other parts of the body, was unrelated to exertion and the patient was generally well. A diagnosis of muscle spasm was made.

Later that evening the patient had a recurrence of the pain severe enough for him to call the out of hours doctor services.

The Patient felt too ill to travel to the out of hours clinic (he lived in a very remote area) and another doctor from the out of hours services travelled to the patient's home to examine him. He again relayed a complaint of epigastric pain, which was sharp with no aggravating or relieving factors. He was prescribed a single dose of Nexium and given a prescription for Zoton on the basis of a diagnosis of acid related indigestion, or ulcer dyspepsia.

Within 36 hours, the patient collapsed and died of acute myocardial infarction. The allegation against both doctors is that one would expect a competent GP to know that myocardial infarction can present with epigastric pain and that when this was severe and persistent in a middle aged man, particularly one who is normally an infrequent attendee at surgery, (and this was clearly not known by the second GP), where there were no signs of an acute abdomen and where the patient was ill enough to prevent him from travelling to the doctor's surgery, that it should be taken seriously enough to warrant hospital referral.

Response: The case on behalf of the Doctors was that it would be completely unreasonable to expect a GP to refer a patient to hospital simply on the basis that two complaints in one day had been made of vague upper epigastric pain.

Furthermore, the patient's family's theory as to how the patient's life might have been saved was predicated on an assumption that a referral to hospital would have resulted in an immediate assessment by a cardiologist.

The expert evidence adduced on behalf of our member was that, even if either doctor had made a diagnosis of heart related pain; this would have made no difference to the final outcome. The patient had symptoms intermittently for several days and was generally well. Even if an ECG had been carried out in the surgery in the first instance it is more likely than not that this would have been normal. A referral to a hospital would have asked for an early appointment to the cardiology specialist clinic where an exercise stress ECG is likely to have been carried out.

It is most highly unlikely that the patient would have been seen within a week or two. Even if the GPs had prescribed aspirin and a beta blocker, and although these would have reduced the risk of death from a heart attack, on the balance of probabilities, the patient would still have died suddenly, despite treatment.

Outcome: The case taken by the patient's family initially commenced hearing in the High Court in Dublin in 2012 but in the light of the very strong evidence adduced by the Defendants the Plaintiff withdrew all allegations of negligence against the General Practitioners.

A FAIR PLAYING FIELD?

WE RUN THE RULE OVER GP'S INVOLVEMENT IN SPORTING EVENTS

As GPs are an integral member of the community, many are actively involved in helping out a local team. Before you pull on that tracksuit, however, it's wise to consider the wider implications of your participation in such events in an official capacity.

We appreciate that some of our members work as Medical Officers at sporting events. We advise that it is essential to establish duties and responsibilities with the Event organisers before agreeing to provide services.

The Medisec Master Policy covers members working at sporting events, provided that the work undertaken is that of a General Practitioner and NOT as the Event Doctor who is responsible for ensuring procedures are in place for the whole event – for example, crowd control, ambulance cover, provision of appropriate medical equipment, etc. Members must provide us with the details prior to the event so that we can confirm cover is in place.

Our Underwriters, Allianz, have written a Best Practice Advice Guide for GPs, who provide services such as Medical Officer at sporting events.

SPORTING EVENTS – BEST PRACTICE GUIDE

Many GPs are requested to provide medical support and/or advice to the various types of sporting events within their community. GPs are generally happy to provide this support however a GP's consent needs to be an informed one. The undernoted comments are Allianz's view on how a GP can ensure they are better informed. There may be other guidance notes from other bodies that could also assist.

RESPONSIBILITIES

The GP's duty of care may depend on the responsibilities assumed. These can vary greatly due to the various sporting events and roles such as, First Aid Doctor, Team Doctor, Doctor in charge of supporters, Doctors in charge of events, Sports medicine etc.
It is imperative that the GP ascertains his/her role, for example

- Do the responsibilities fall with the scope of normal General Practitioner activities?
- Are you responsible for participants and competitors only?
- Are you responsible for the spectators?
- Are you being asked to be the Event Doctor i.e. ambulance cover, crowd control, emergency/disaster planning, First Aid provision/support etc. If so, this would not be deemed "normal GP work" and alternative arrangements should be made with the event organisers for Cover
- Are you in charge of a Medical Team (physiotherapists, First Aiders, paramedic) and have you assessed their competencies?
- Have you carried out Risk Assessments on the equipment, personnel, situation etc.?
- Have you ascertained Communication Procedures are adequate, two way radio, black spots etc.?
- Does the event require knowledge of the County's Major Incident Plan?

COMPETENCY AND TRAINING

Keeping up to speed with the game at hand

Just as an athlete needs to keep abreast of the latest training methods, so a GP should be familiar with advances in best practise at sporting events.

Once a GP has ascertained their duties and responsibilities, it is important to self-audit and confirm that they have the required competencies (bearing in mind that there could be other competency requirements depending on the event), for example:

- Attend &/or refresh a Pre-Hospital Trauma Care course (mandatory for some events) every three years
- Attend &/or refresh an ATLS course every three years
- Have a basic knowledge of the sport and its rules and potential risks
- Have a basic knowledge of the fitness levels to participate safely in the sport
- Have the appropriate knowledge, experience and equipment to deal with the common, possible or probable injuries
- Be familiar with and adhere to the Code of Practice (if available) for the Sport in question
- Have the appropriate knowledge of the communication systems and procedures.

INDEMNITY

Don't be caught offside

The Allianz policy will indemnify GP's in respect of liability arising from advice and/or treatment coming within the range of services normally provided by a General Practitioner, i.e. if it isn't a normal GP activity, it isn't covered (refer policy wording for full terms and conditions). This is an important consideration for you as the GP having due regard to the responsibilities, duties and competencies required for the particular event with which you are being asked to become involved. It is also worth mentioning that, if signing agreements, you should also be aware that your indemnity would not cover any liability that you may have assumed under any contract, agreement, warranty or guarantee that would not otherwise have attached.

We appreciate the local underage soccer team may not require the same investment as a racecourse event or motor rally. However, as a GP, the same process or "tests" should be applied to any event you are being asked to assist.

Make sure you are making an informed decision and have the correct indemnity and if in doubt, contact Medisec.

GP ACTION POINTS

Here is a checklist of various things you should take into account as you assess any individual sporting event:

- Confirm the people for whom you are responsible (notwithstanding Good Samaritan).
- Assess the competencies of the people you are responsible for.
- Confirm you have the competencies noted above.
- Perform a risk management assessment e.g. the possible risks from the sporting event?
- Prepare for pre-existing conditions that may be exacerbated e.g. asthma, epilepsy etc.?
- Assess if alcohol consumption is a likely factor that may affect duties/responsibilities.
- Is the potential capacity/attendance a factor that could give rise to incidents.
- Confirm the responsibilities of other people i.e. organisers, club, sporting association etc.
- Equipment. Is equipment the GP's responsibility? Confirm there is adequate equipment and facilities. Is the location of equipment correct and are you trained in the use of such equipment?
- Check if there is a Safety Statement prepared by the event organisers and a Specific Plan, Code of Practice for the Sport, adherence to the Safety in Sports Arena 1996 Document or any other legislation.
- Be aware of the Major Incident Plan.
- Check the communications procedures for effective and efficient two way communication.
- Ensure good record keeping and use the same protocols as you would in your own practice.
- Be aware that Doctor/Patient confidentiality applies and the same ethical and legal rules must apply.
- Disposal of sharps or clinical waste; are responsibilities and procedures in place?
- Ensure you are identifiable.

A HEALTHY DOSE OF SOUND ADVICE

SAFE PRESCRIBING AND MEDICATION MANAGEMENT

Prescribing is a large part of a GP's practice and includes prescription of medication, medical devices or dressings. As a GP you should have comprehensive knowledge of and comply with the relevant statutes, legislation and guidelines governing the prescribing of medicinal products[7].

A recent study in the UK into GP prescribing by the General Medical Council found that 1 in 5 prescriptions contained significant errors mainly regarding drug dosage and lack of instructions. Time pressures during consultation, complex computer software that made it easy to select the wrong drug or incorrect dose from drop-down menus and frequent distractions and interruptions during consultations were cited as the main contributing factors[8].

PRESCRIBING GUIDANCE

Most GP prescriptions are now computer generated but if you are writing one by hand-write legibly in indelible ink. All prescriptions at a minimum should include: the date; the name address and telephone number of your GP practice; the patient's full name, date of birth and address (DOB or age mandatory if child under 12); the medication, dose, strength, route and frequency should be clearly stated. All prescriptions must be signed by the prescriber and include the prescribers Medical Council Registration Number, or, if relevant, the Registered Nurse Prescribers Registration Number.

PATIENT INFORMATION

When issuing a prescription to a patient carefully explain:
- The likely benefits, risks and common side effects of the treatment. Advise they read the patient information leaflet in the drug packaging.
- What to do if a side effect occurs.
- How and when to take the medication and how to adjust the dose if necessary.
- The likely duration of the medication.
- Arrangements for monitoring, follow-up and review if necessary.

SAFE PRESCRIBING-ISSUES WHICH YOU NEED TO CONSIDER

- *Primum non nocere* First-do no harm and the sound advice of Hippocrates is still relevant today. Prescribe only when necessary taking into account all benefits and risks to the patient. Informed consent of the patient is as important in prescribing as any other aspect of patient care so involve the patient about decisions in their treatment and respect patient autonomy.
- Note the patient age and medical history (particularly hepatic or renal problems) and any previous adverse reaction to medicines. Before prescribing any medication or treatment ensure that you have adequate knowledge of the patient's condition and are satisfied that the drug or treatment will serve the patient's needs.
- Prescribe effective medication or treatments based on sound up-to-date evidence.
- Ensure that the medication or treatment you are prescribing is compatible with any other treatment the patient is receiving. Encourage patient's to disclose if they are taking any other medicines including non-prescription and herbal medicines, illegal drugs or medicines purchased online.
- Think about dosage carefully and do not assume 'one dose fits all'. This is particularly important when prescribing for young children or the elderly. Avoid unnecessary use of decimal points when prescribing ie. 3mg not 3.0mg or 500mg not 0.5g.
- Avoid the of use abbreviations except for some acceptable Latin prescribing abbreviations such as prn, qds, tds, od etc
- Avoid abbreviation of drug names as these can be misinterpreted.
- Clearly document in the patient's records the relevant clinical finding, the diagnosis made, the information given to the patient and any drugs or treatment prescribed.

REPEAT PRESCRIPTIONS

It may be routine for other members of staff to write up or computer generate repeat prescriptions for you to sign. Whilst this may save time it is not without risk. Always ensure that:
- Correct prescription for correct patient.
- That the patient is reviewed regularly in terms of drug side-effects and with regards to the ongoing need for this medication - Medisec recommends at least annually.
- The correct dosage is issued if there are changing doses over time.

Remember-You are ultimately responsible for these prescriptions and if a prescribing error occurs you are the one likely to be held accountable.

PRESCRIBING FOR YOURSELF OR RELATIVES

According to Medical Council guidance you should not self-prescribe and if you become ill should consult another doctor rather than treat yourself. You should also avoid prescribing to relatives except in the case of minor illness or in an emergency. If you do prescribe medication for a relative make a clear record of it including the reason for it, your relationship with the patient, and the reason it was necessary for you to prescribe.

KEEPING-UP-TO-DATE IN PRESCRIBING

It is essential that any practitioner prescribing medicines keep-up-to-date with ongoing developments on PILs and SPCs and ensure prescriptions are appropriate. Stay on the safe side-if you are unsure about interactions or other aspects of prescribing and medication management, look it up or consult an experienced colleague. There are a number of sources of information available to support you in this, including guidance from the Irish Medicines Board, the Irish and British Medicines Formularies, NICE and websites such aswww.medicines.ie, www.medicines.org.uk, www.ema.europa.eu.

[7] Misuse of Drugs Acts 1977 & 1984; Medical Council Guide to Professional Conduct and Ethics 2009 para 59.2
[8] GMC 2nd May 2012
[1] Medical Council Guide to Professional Conduct and Ethics 2009 Para 51.2 52.1

The National Standards for Safer Better Healthcare were launched by HIQA in June last year. The Standards describe a vision for high quality, safe healthcare and provide a framework against which services must deliver them safely. In the next few years, Licensing of Primary Healthcare Centres and all Practices will come into play as HIQA have the legislative responsibility to enforce the standard under their National Standards for Safer Better Healthcare.

Medisec recognise the many challenges that this will pose for our members and, against this background, have been looking at the providers of standards such as the Joint Commission International (JCI), CHKS and Irish Primary Healthcare Standard (IPHS) to see what and how they can offer our members support.

We recently visited IPHS in its development site Mallow Primary Healthcare Centre (MPHC) and were introduced to the standard by Dr David Molony, GP and Mr Damian Casey, Facilities Manager. They were kind enough to share the following article with us, which we reproduce here:

Mallow Primary Healthcare Centre (MPHC) felt the need to demonstrate and measure patient care and standards in a comprehensive and recognisable manner. Having looked at systems around the world, we had our primary care project in Mallow built to the highest medical building standards that we could find, namely the UK Technical Memorandum Standards.

Since then, the Irish Primary Healthcare Standard (IPHS) has been developed over the last 6 years with the co-operation of different individuals experienced in clinical, management and scientific standards development as well as patient group input and from a retired auditor Billy Nyhan, who spent many hours sitting in the practices gaining an understanding of their operations.

Why would a primary care standard help in the operation of primary care facilities/general practice?

First of all, general practices and primary care facilities are businesses and need to be run as efficiently and effectively as any business. Management standards need to be of the highest quality if the business is to succeed and provide resources for the delivery of patient care. Staff and patient risks have to be assessed regularly and acted upon and every general practice is legally required to have an up-to-date practice safety statement. GPs now need to have audit systems built into their working environment to satisfy the Irish Medical Council guidelines for registration.

The main emphasis of the IPHS standard has been to develop a documented process of risk assessment, management and continuous improvement as we feel the ethos of identifying problems and putting corrective actions in place better supports a patient focussed service. This also supports the up-skilling and protection of staff, whilst maintaining the highest standards.

It is important to emphasise that this is not a new process because all practices are expected to have the highest standards but, to date, they have only been measured in hindsight, i.e. through the Irish Medical Council or the Courts. It is our experience that practices in Ireland have a very high standard but do not have all the information readily available as will be required by regulators.

HIQA see their National Standards for Safer Better Healthcare as the barometer for future healthcare licensing. These standards "are aimed at protecting patients and they provide, for the first time, a strategic approach to improving safety, quality and reliability in our health services. They will form the basis for future licensing of all healthcare facilities in Ireland".

To remain in operation, doctors are going to have to demonstrate annually that they run a safe practice, take cognisance of the needs of patients and are complying with the enormous weight of legislation that applies to them. At first glance, this seems an onerous and impossible task but when we realise how well organised most practices are, then the task, though large initially, is not impossible and, once documented procedures are in place, it should be easy to maintain.

There are 3 levels to which primary care facilities/practices are accredited to IPHS.

Level 1: The primary care facility/practice fulfils all legislative requirements, i.e. Safety Statement, Risk Assessments, Irish Medical Council and legislative requirements.
Level 2: The primary care facility/practice has a higher management standard and is monitoring their activities and processes with a continuous improvement programme.
Level 3: The primary care facility/practice has a commitment to the highest standards attainable, consults regularly with patient groups, measures and reviews clinical, management and financial key practice indicators and shows a high level of community involvement.

IPHS defines the controls required to demonstrate compliance and best practice with the management standard for Primary Healthcare Centres (A Primary Healthcare Centre is any centre providing pre-hospital medical care and can comprise single and multi doctor practices). It acknowledges and complies with the fundamental principles of the following international standards and best practice guidelines:

- ISO/OHSAS 18001:2007 Occupational Health and Safety Standard
- National Hygiene Services Quality Review 2008: HIQA
- National Standards for Safer Better Healthcare 2012: HIQA
- Guidance on Information Governance for Health and Social Care Services in Ireland 2012: HIQA
- National Standards for the Prevention and Control of Healthcare Associated Infections 2008 : HIQA
- Joint Commission International Accreditation Standards for Primary Healthcare Centres 2008
- Health & Safety Authority Ireland
- Legislation, Regulations, Reports and Codes of Practice

IPHS provides the structure, the format and the review systems that are required in this new environment, whereby if you fail to record something, then it did not happen. It provides an increase in positive interaction with patients, visible evidence in the practice of the application of a standard, such as mission statements on walls, assurances of confidentiality, respect, complaints procedures and better patient care. It provides staff with a sense of responsibility, understanding of their roles, sources of legislative and other information as well as structured patient care.

From a management point of view, IPHS provides management review structures to oversee all the processes, review legislative requirements on an ongoing basis and provide the structure to review Key Practice Indicators (KPI) in clinical, management and financial areas.

IPHS covers the following areas:

- Definition and communication of a health and safety policy
- Risk assessment and controls throughout organisation, clinical and operational.
- Safety representative and clear responsibilities of all agreed and documented.
- Documentation of a management manual, document and data system.
- Identification and management of all appropriate legal and other requirements (including, for example, various codes of practice and advisory documents).
- Process guidelines and controls identified, documented and managed (this includes maintenance and calibration of all critical equipment).
- Management of continuous improvement programmes, identification of objectives and targets. Development of Quality Improvement Plans.
- Involvement of all staff and interested parties in all appropriate aspects of the business and improvement process.
- Internal system and regulatory audit compliance process.
- Identification, management and testing of response to all potential emergency situations (fire, accidents, spillages, pandemics, etc.)
- Training (includes identification of training needs, CPD and ongoing training plans for all practice staff) and recording of all training.
- Eventual integration of quality, environmental and safety systems.

There is a cost in initially implementing standards and there is a cost involved in the certification process itself. At IPHS we expect that these costs will be recouped from increased efficiency, identification and eliminate waste, more efficient staff use, identification of responsibilities and organised review of patient care programmes. All processes and activities are reviewed routinely and it is for these reasons that IPHS is an ideal tool for continuous improvement.

The IPHS standard has been introduced to 12 other practices, including most recently a 5 modules course given to practices in the South West Training Scheme in Tralee. There are a number of practices in Cork City and County and Wexford, exploring the possibility of attaining the standard.

For more information on the IPHS standard, please contact Dr David Molony or Damian Casey at **damian.casey@mphc.ie**

MEDISEC RED FLAGS

Under this banner, we'll be pointing out some "red flag" issues in future editions of On Call where we highlight areas where you may not be covered under the terms of what constitutes normal GP work.

ULTRASONOGRAPHY

The Medisec Master Policy does not cover use of Ultrasonography in ante natal care or obstetrics.
Our GP Advisory Panel have reiterated that Ultrasonography, if used as an aide to treatment, as opposed to diagnostic use, is considered normal GP work, but that the issue of cover should be reviewed on a case by case basis.

HOME BIRTHS

Home births including any Domino birth pilot projects do not, it was agreed by the GP Advisory Panel, come within the scope of activity considered normal GP work and are, therefore, not covered under the Policy.

PRE AND POST NATAL CARE

The GP Advisory Panel are of the view that if the patient ticks yes for a domiciliary delivery under the "Mother and Infant Scheme Application Form" (Section 62 and 63 of Health Act 1970 then our members should not under any circumstances sign this form as any involvement in a home birth is excluded from the Medisec Policy, with the exception of an emergency "Good Samaritan" involvement, should it arise.

NOTES

Only information relevant to the patient and his or her condition or illness should be recorded in the patient's chart. Unless relevant, information concerning others should not be included. If a patient makes allegations about other persons, these should only be recorded if relevant. Information which may be provided by a third party, such as a relative, is governed by the same rules of confidentiality as apply to information and investigations carried out on the patient.

It is recommended that, where information is provided by a third party, the fact that this information is provided by a third party should be recorded in the notes to avoid misinterpretation.

VOICING CONCERNS ABOUT THE DRAFT GMS CONTRACT FOR UNDER SIXES

Medisec has been monitoring developments on the draft Contract for Under 6s. As a Private Company, we do not comment publicly on matters of State health policy nor are we involved in any negotiation or discussion of contractual terms and conditions for GPs.

However, we believe you should be aware of concerns we have on the insurance, indemnity and warranty provisions which go beyond the scope and range of cover of the Medisec policy underwritten by Allianz and that may leave you exposed if you were to sign the contract and suggest you refer to www.medisec.ie/news

Quick Tips following a recent Claims review

IMPLANON

If the implant cannot be palpated after insertion, patients must be advised to use alternative methods of contraception until confirmation the implant is in place.

GP PRACTICE

If a locum is working in a Practice, the GP's computer system should not enable a locum to log on as a named GP in the Practice - the GP should log on as a visitor only.

PATIENT NOTES

A reminder that comprehensive notes should be written up after all consultations. A claim is usually indefensible if there are no notes. It is a Medisec Policy Requirement.

TAKING THE HIGH ROAD

WHEN LIFE BEHIND THE WHEEL BECOMES AN ISSUE

Getting into your car and setting out on the open road is one of life's great freedoms and any GP is loath to curtail anything that would affect a patient's individuality and sense of self. A car is, however, a lethal mechanism in the wrong hands and there is a wider obligation to the general community. This tricky balancing is something all GPs will have to deal with at some stage and the following guidelines can cast some light on this grey area.

"Medical Fitness to Drive Guidelines" were compiled by the National Programme Office for Traffic Medicine which has been established as a joint initiative between the Royal College of Physicians of Ireland (RCPI) and the Road Safety Authority (RSA).

The Guidelines, which came into effect in February 2013, are intended to assist doctors and other healthcare professionals in advising their patients on fitness to drive. The document provides doctors with guidance on medical fitness to drive under broad headings of Neurological disorders, Cardiovascular disorders, Diabetes Mellitus, Psychiatric disorders, Drug and alcohol misuse, Visual disorders, Renal disorders, Respiratory and sleep disorders.

Medisec frequently receives requests on obligations and requirements for reporting to the Driving Licensing Authority. Importantly the Guidelines impose a positive duty on health professionals to notify the Road Safety Authority in writing of a belief that a patient is physically or mentally unfit to drive, poses a risk to public safety and is not compliant with professional advice to stop driving.

Medisec strongly recommends in line with the Guidelines that any action taken by GPs should be taken with the consent of the patient wherever feasible. However, if such consent is not forthcoming and the GP believes that a patient is unfit to drive notification to the RSA should be undertaken with the patient's knowledge of the intended action to the greatest extent possible. To maintain the doctor patient relationship is important. While acknowledging the duty of healthcare professionals to maintain patient confidentiality, the Guidelines also emphasise that this duty is legally qualified in certain exceptional circumstances in order to protect public safety.

The Guidelines are available on the website of the RCPI www.rcpi.ie or on the RSA website www.rsa.ie.

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