FACTSHEET

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Risk Management in General Practice

The reduction of medical error and the enhancement of patient safety has become a key focus for all healthcare providers and an integral part of all healthcare delivery. Providing high quality safe care to patients in the community is the aim of all GPs. However, patients can be inadvertently harmed as a result of an event or circumstance that occurs during their care.

The Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 9th Edition, 2024 (available on the Medical Council website) refers to patient safety at paragraph 2.1:

You must practise and promote a positive culture of patient safety. This includes:

- *Providing a good standard of practice and care, maintaining your professional competence and keeping your knowledge and skills up to date, reflecting on your practice and working within your sphere of competence.*
- *Supporting and demonstrating effective communication, partnership and teamwork with patients and colleagues.*
- *Identifying concerns about the quality of patient care and services and notifying these to the appropriate person or authority.*
- *Encouraging and supporting a culture in which staff can raise concerns openly and safely at all levels.*
- *Contributing to improvements in the quality of services and outcomes.*
- *Complying with and supporting safety procedures such as infection control, incident and risk management.*

Research suggests that 2%–3% of primary care encounters are involved in a patient safety incident, and approximately 1 in 25 of those result in a significant harm outcome that has a significant impact on a patient's wellbeing.

Clinical risk management provides a strategic approach to improving patient safety by:

- Identifying the nature and frequency of risks and medical errors;
- Developing robust systems and processes to minimise healthcare risks; and,
- Reducing the risk of incident recurrence to as low as reasonably practicable.

Having robust systems and processes in place will also assist in protecting individual clinicians and practice teams in reducing their risk of complaints and litigation.

The Medical Council's Ethical Guide describes the leadership values that support good patient care.

Paragraph 11 Leadership and management for doctors:

> *11.3 As well as good standards of clinical care, safe patient care requires a well organised practice supported by robust systems, appropriate record keeping, organisation of rota and cover arrangements, among others. Depending on your level of authority you should work to improve systems and raise concerns with an appropriate person or authority if you believe processes and administrative systems in the healthcare setting are impeding good patient care.*

11.4 If you identify incidents or risks to patient safety in the healthcare system, you must take appropriate action to manage these and to make the necessary notifications.

Developing protocols and procedures within the practice to enhance patient care

Good risk management involves the development of systems that reduce the likelihood of patient harm by setting standards and procedures for the practice. Protocols summarise these standards and procedures. By following such protocols, all staff members should be practising in the same way and therefore contributing towards good clinical governance within the practice.

Having protocols in place is also both a contractual and legislative requirement in certain instances, such as a requirement to have a complaints policy in place under the GMS contract and implementing a child protection policy in line with the Children First Act 2015. Protocols can also demonstrate that an organisation places appropriate emphasis on careful risk management. This may be helpful in dealing with serious complaints, litigation or when having an external review by a body such as Health Information Quality Authority (HIQA).

Protocols outline areas of responsibility and are written evidence of the standard of care to be provided to patients. When developing protocols, it is advisable to take a team-based approach. Where protocols are developed in isolation, this may result in a lack of ownership by other members of the practice team. This can detract from the usefulness of the protocol and can result in members of the practice team carrying out their work in different ways with variable standards, to the detriment of patient care.

When developing practice protocols you may wish to consider the following:

- Discuss and agree the content of the protocol with all relevant members of the practice team;
- Involve the relevant members of the practice team (e.g. doctor, nurse and administrator) in their development, as protocols within a practice rarely involve just a clinical process;
- Include tools such as flow charts and algorithms, as appropriate;
- Include the name of the author(s) and state the date the protocols came into effect;
- Review regularly and amend/update when necessary and appropriate;
- Ensure all protocols are easily accessible to all staff members; ideally electronically, e.g. on a shared folder/drive on the practice computer system;
- All out of date protocols should be stored in an archive folder; you should keep a log containing the title of the protocol and the date it was implemented and withdrawn.
- Out of date protocols may be relevant if responding to a complaint and/or claim and; therefore, it is important to store and be able to access old protocols for those purposes.

Developing clinical protocols

In addition to administrative protocols, developing clinical protocols is a useful educational exercise that allows the clinical team to review their current practice, having regard to local, national and international guidelines.

GPs and nurses may wish to consider which common clinical treatments/actions within the practice would benefit from being documented as protocols to promote a consistent approach in a given set of circumstances; for example, immunisations, venepuncture, ear syringing, chronic disease management, prescribing, managing test results etc.

When developing clinical protocols you may wish to consider addressing the following key areas:

- Knowledge and skills framework necessary to assess clinical competency;
- Risk assessment of the procedure and environment;
- Documentation and record-keeping;
- Evidence/ research and appropriate up-to-date clinical guidelines;
- Availability of local services;
- Identify who carries out key parts of the care or treatment;
- When to seek an opinion of another colleague, i.e., in what circumstances should a practice nurse escalate a concern about a patient to a GP, e.g., bleeding during a cervical smear etc.; and,
- Consent to treatment.

Once clinical protocols have been agreed by the practice team involved in their development, they should be read by all relevant staff members and signed to confirm that this is the case. Clinical protocols should be reviewed and updated at an agreed time interval, or sooner to reflect any amendments/updates to clinical guidelines.

At Medisec, we have developed a suite of template policies and factsheets on a variety of topics to assist you in your daily practice, to include:

- *Managing complaints within general practice;*
- *Safe management of test results;*
- *Repeat prescribing in general practice; and,*
- *Children First – a guide to compliance in general practice.*

For further information or to obtain a copy of our template policies please contact a member of the Medisec team.

Build a Safety Culture within your practice

The safety of healthcare requires that organisations, including general practice, build and maintain a safety culture; this is part of a systems approach. The idea of safety culture is important as it has been shown to be a key predictor of safety performance in high-risk industries. It is the difference between a safe organisation and an accident waiting to happen. Thinking and talking about safety culture is essential for the practice team to understand what they do well and where improvements are required.

A safety culture within a practice team can be described as having the following key attributes:

- The leadership and individual practice team members have a constant awareness of things that can go wrong;
- Individuals and practice teams acknowledge mistakes, commit to learning from them and take action to reduce the risk of reoccurrence;
- Communicate clearly with patients and engage them as partners in their care;
- Staff members are encouraged to speak-up if they see something wrong and are reassured of having a secure environment to discuss their concerns without fear of reprimand;
- Leadership and individual team members recognise, highlight and embed existing good patient safety practices into their daily work.

Frequently, when things go wrong our instinct can be to focus blame on individual error. However, most adverse events are rarely the result of a single isolated incident or the actions of one individual. Healthcare teams with a positive safety culture are more likely to learn openly and effectively from mistakes and adapt their working practices and systems accordingly to reduce future risks. In many patient safety incidents, a poorly developed safety culture can be implicated as a significant contributory factor.

Errors and incidents in healthcare occur within a system and usually there is a sequence of events that occur before an accident happens. Ideally all staff members working in general practice should adopt a "*just culture*" approach to adverse events.

A "just culture" approach considers the wider systemic issues when things go wrong, thus enabling healthcare staff and those involved in the system to learn from what went wrong without fear of retribution. In a just culture, practice staff should feel psychologically safe and know they will be treated fairly and supported when reporting errors. Staff members should be encouraged to openly disclose adverse events and near misses to management and seek assistance when faced with challenges beyond their competence.

All staff members should be aware of how to report adverse events within the practice and training should be provided on how to undertake effective significant event analysis following an adverse incident.

In summary

General practice is a continuously evolving complex healthcare environment. There is a correlation between risk management safety culture and patient safety, which is dynamic and complex. Working in general

practice is not without risks and errors and incidents will occur. Practice teams should strive to minimise those risks by ensuring their risk management systems are safe and robust.

When things do go wrong, openness and transparency together with a commitment to learning and avoiding the 'blame game' are vital to a practice's safety culture and will allow for meaningful improvements to reduce and minimise the risk of incident recurrence to as low as reasonably practicable. A clear focus and a team approach to risk management and patient safety will in turn help foster a safety culture with your practice and enhance the quality of patient care delivered by all team members.

If you have any specific queries in relation to the content of this factsheet, please contact a member of the Medisec team.

The contents of this publication are indicative of current developments and contain guidance on general medico legal queries. It does not constitute and should not be relied upon as definitive legal, clinical or other advice and if you have any specific queries, please contact Medisec for advice.

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