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Professional support and expert advice for GPs and practice staff
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Putting members first

Infection control – time for a clean sweep?

Why all general practice staff play a vital role in preventing infection

PAGE 5

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What's inside...

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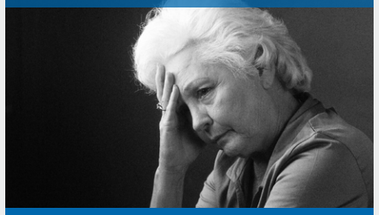

PRACTICAL PROBLEMS

CAREERS

Meet your Regional Membership Co-ordinator: Rachel Lynch

Rachel has worked in the Marketing Department at MPS for more than ten years: "I regularly visit medical schools and hospitals to talk to members and arrange medicolegal events for some of the professional organisations in Ireland, including the Royal Colleges.

"If you would like a visit to talk about your membership, or you are organising a teaching event, training day or conference, then you can contact me to help arrange sponsorship or a speaker."

Contact her on **087 2867491** or at **rachel.lynch@mps.org.uk**

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We welcome contributions to *Practice Matters Ireland*, so if you want to get involved, please contact us on +44 113 241 0683 or email: sarah.whitehouse@mps.org.uk.

Welcome

Dr Sonya McCullough – Editor-in-Chief, MPS Medicolegal Adviser

Welcome to the latest edition of *Practice Matters Ireland*.

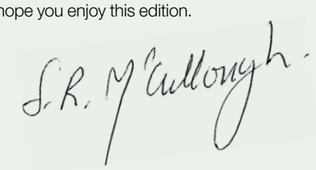
Creating a safe healthcare environment for your patients is a team effort. In this issue, we take a look at infection prevention and control, which is the responsibility of everyone in your practice, from the cleaner to the GP partner. On page 5, MPS Clinical Risk Programme Manager Julie Price offers practical tips to ensure you have a robust policy in place for the prevention and spread of infection.

Good infection control is imperative when it comes to minor surgery, too. Increasingly, GPs are performing minor surgery in practices. But potentially no intervention is minor, and there are numerous potential pitfalls to recognise, and avoid, in order to keep your patients – and yourself – safe. Dr Diarmuid Quinlan highlights these on page 8.

Our Careers section takes a look at another risk area – prescribing – on page 10, whilst pages 12 and 13 chart the potential routes newly-qualified GPs can take for their next steps into the world of general practice.

Thank you to those of you who took part in our recent *Practice Matters Ireland* member survey. Your feedback and suggestions for improvement are invaluable – and we will be putting these into practice for the next edition. Look out for more case reports and practical medicolegal guidance.

We hope you enjoy this edition.



Follow us on Twitter

Good news for those who like to be kept up-to-date whilst on-the-go – MPS is now on Twitter! If you use Twitter in a professional capacity, why not follow **@MPSdoctorsIRE**?

How do you handle adverse outcomes?

Research shows that the way in which you communicate with a patient when something has gone wrong is one of the key factors in deciding if a patient will make a complaint or consider a claim. Yet most doctors receive little or no formal training in how to communicate in what can be a difficult and stressful situation.

Mastering Adverse Outcomes is designed to fill this gap, providing you with powerful techniques that can reduce your exposure to risk of complaints or claims. Topics covered include how to communicate with patients when something has gone wrong, and the cultural and legal implications of expressing regret.

Benefits of attending:

- Earn 3 CPD points per workshop
- Free for MPS members to attend. €175 for non-members.

The latest dates are now available:

25.09.2014 - 14.00 – 17.00
River Lee Hotel, Cork

03.10.2014 - 14.00 – 17.00
Crowne Plaza Blanchardstown, Dublin

11.10.2014 - 14.00 – 17.00
Crowne Plaza Dublin Northwood, Dublin

21.11.2014 - 09.30 – 12.30
Crowne Plaza Blanchardstown, Dublin

25.11.2014 - 09.30 – 12.30 or 14.00 – 17.00
Crowne Plaza Blanchardstown, Dublin

To book your place visit www.medicalprotection.org/ireland/workshops or call +44 (0)113 241 0696.

MPS General Practice Conference 2014: Spotlight on Risk

Saturday 13 September 2014

The Convention Centre, Dublin

Cost: €75 for GP MPS members and €40 for GP Trainees, Practice Managers and Practice Staff

Now in its third year, our annual conference for GPs and the primary care team will put the focus on top risks in practice and offer practical advice on how to manage these risks. Understanding the medicolegal and ethical problems you face on a day-to-day basis is vitally important, and you need to know how to quickly and efficiently deal with them when they arise. This one day conference will cover key topics including:

- Working Together as a Team
- Shared Decision Making
- The Importance of Open Communication
- Developing a Safety Culture in Your Practice
- Prescription for Happiness
- When Things Go Wrong.

For more information about the conference and to secure your place please visit the MPS website: **www.medicalprotection.org/ireland/gp**

Guiding you through the claims process

Following member feedback, MPS has launched a new way of supporting members when they receive a clinical negligence claim. Designed to provide you with an efficient and informative service, the new process will streamline the experience for members who find themselves on the receiving end of a claim. A new *Claims Guide* provides clear information about how MPS can help, and explains the legal process step by step.

Look out for more details in the September edition of *Casebook.*

MPS on tour…

- On 10 May, MPS presented an interactive role play, 'Doctors in the Dock,' at the ICGP Annual Conference.
- In May, MPS ran a series of '*Taking control of your risk*' roadshows for members of the general practice team in Cork, Sligo and Galway. The roadshows provided members with an insight into some of the reasons why patients sue, and what can be done to reduce the risk of it happening to you.

Infection control – time for a clean sweep?

All general practice staff play a vital role in infection prevention and control, says Julie Price, MPS Clinical Risk Programme Manager

Riverside Medical Practice received a complaint from Mrs A, a pregnant 35-year-old patient. She had recently seen GP Dr F for an antenatal examination. Mrs A was unhappy with the care that she had received and complained about numerous infection control issues during her visit:

- When Dr F examined her, she noticed that he didn't wash his hands before he palpated her abdomen, or afterwards.
- She was asked to lie down on an examination couch covered with a cloth blanket and a soiled pillow. She enquired how often the blankets were washed.
- When she visited the patient's bathroom in order to provide a specimen she was disgusted with the cleanliness of the room and that only a 'grubby looking towel' was provided for drying her hands.

Mrs A changed practice. The secretary later heard that Mrs A told her friends she left the practice as she didn't want to bring her newborn baby to unclean premises. What if Mrs A is not alone? What if patients are leaving your practice because of inadequate infection control practices?

Do you provide patient care in a clean and safe environment where the risk of infection to patients and staff is kept to the minimum? Have you a robust policy for the prevention and spread of infection within your practice?

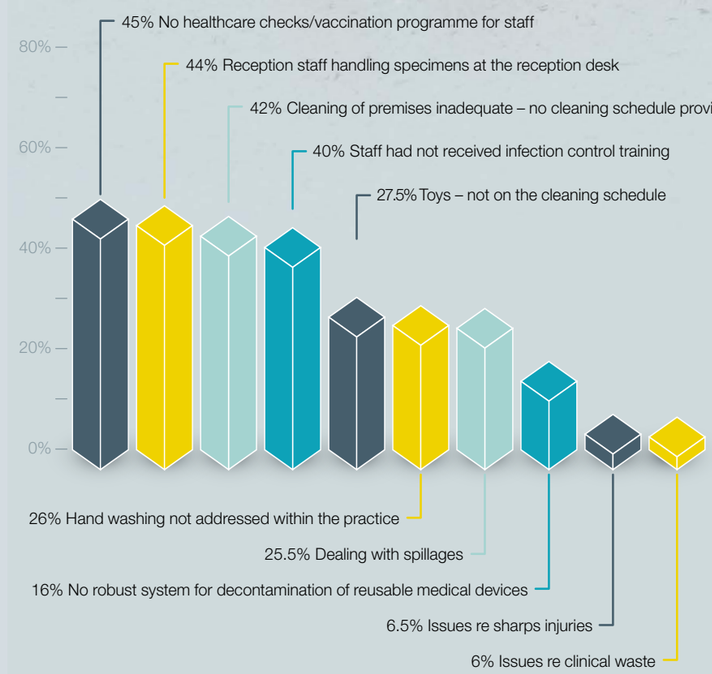
Healthcare associated infection (HCAI)

HCAIs are infections that are acquired as a result of healthcare interventions and can lead to serious illness, long term disability and even death. HCAIs are not just confined to hospitals: general practice teams need to have suitable arrangements in place to ensure patients experience care in a clean environment.

Risk associated with infection control

MPS undertakes Clinical Risk Self Assessments (CRSAs)[1] of general practices, which are a systematic approach to identifying risks and developing practical solutions to ensure quality practice and prevent harm to patients. Data collected from 153 CRSAs conducted during 2013 across the UK and Ireland reveals that 89% of practices visited had issues regarding infection control.

The main risks highlighted are detailed in the graph:



So, let's consider some of these key risks and how these may impact on your practice.

Staff immunisation

In 45% of practices visited, GPs had not considered vaccinations required for members of staff. The *Safety, Health and Welfare at Work (Biological Agents) Regulations* 2013[2] makes provision for this if there is a risk to the health or safety of employees caused by working with a biological agent. A biological agent includes a virus, bacterium or fungus that has an ability to adversely affect human health.

The *Infection Prevention and Control Guidelines for Primary Care* state: "In addition to GPs and Practice Nurses, administrative and cleaning staff may be exposed to communicable diseases and/or blood/bodily fluid exposure, and therefore should be vaccinated as appropriate. Decisions about vaccinations recommended should be based on the duties of the individual rather than on job title alone."[3]

Recommendation: All clinical and non-clinical staff should be offered vaccination if a risk assessment reveals that their work may expose them to blood borne virus infection and other infectious diseases, eg, Hepatitis B, influenza.[2] Please also refer to the RCPI's *Immunisation Guidelines for Ireland*.[4]

Specimen handling

How often do reception staff handle specimens within your practice? Do patients bring samples in inappropriate containers and pass these directly to the receptionist? The outside of the container could be contaminated. Forty-four percent of practices visited in 2013 had risks associated with specimen handling.

Recommendation: Reception staff should not touch patient specimens and samples in inappropriate containers should not be accepted. GPs should issue the patient with a labelled specimen container when requesting a specimen, removing the need to decant samples. A box could be provided at the reception desk for patients to leave their samples, which can be passed straight to the nursing staff.

Cleaning of premises

Of the practices visited in 2013, 40% had risks associated with cleaning of the premises. This did not relate to the effectiveness or efficiency of those undertaking the housekeeping roles, but rather to the schedule of cleaning for each practice.

Recommendation: Have a regular, planned and monitored cleaning schedule which provides details about how the environment and equipment (eg, chairs, examination couches) are to be cleaned – and how frequently.

Wash and change floor mops regularly. Mops, buckets and cleaning cloths should be colour coded and different mops/cloths should be used to clean clinical and public areas. Mops should be hung to dry and should not be left wet in buckets.

Training

Forty percent of practices did not provide staff training on infection control. Appropriate infection control is integral to the health and safety of patients, practitioners and staff. With the right systems, processes and training, the risk of infection can be detected and managed.

Recommendation: Provide staff with training in infection prevention and control at induction and through regular updates. Topics should include: hand washing, management of sharps and clinical waste, and management of spillages of blood and body fluids, among others.

Toys

In MPS experience, many waiting room toys are not cleaned routinely. Soft toys are hard to disinfect and rapidly become re-contaminated after cleaning, whereas hard toys such as a bead frame or activity table can be easily disinfected.

Recommendation: Remove all soft toys from the practice. Regularly check hard toys to ensure they are safe and clean regularly as part of the cleaning schedule.

Hand washing

Twenty six percent of practices visited did not provide staff with hand washing training. Effective hand washing prevents the transmission of micro-organisms to yourself and others – it's the single most important procedure for infection control.

Recommendation: Teach all healthcare staff how to correctly clean their hands with alcohol handrub and with soap and water.
Ideally you should make available:

- Liquid soap dispensers
- Appropriately placed alcohol handrub product
- Paper towels – cloth towels are a recognised source of cross-infection
- Elbow-operated mixer taps
- A designated hand washbasin, separate from the one used for equipment.

Alcohol handrub is the recommended product in all patient care situations except:

- After contact with a patient with known or suspected diarrhoea, eg, clostridium difficile or norovirus
- Where hands are visibly soiled
- If there is direct hand contact with bodily fluids, ie, if gloves haven't been worn
- If the patient is experiencing vomiting and/or diarrhoea.

In these instances, hand wash with antiseptic soap or plain soap followed by use of an alcohol rub is recommended.
Staff should have access to suitable personal protective equipment such as gloves, aprons and eye protection.

Dealing with spillages

Spillage kits were not available in 25.5% of practices visited. Blood and body fluid spills should be dealt with quickly and effectively. All staff should know who is responsible for spillage management in their work area. In clinical areas this would normally be the nursing staff. Domestic cleaning may also be required after the body fluid spillage has been dealt with.

Recommendation: Consider providing a 'grab bucket' containing all the relevant equipment to deal with a spillage of body fluids. The kit should be kept in a designated place (you may need more than one kit). The kit should comprise:

- 'nappy' type bucket with a lid
- non-sterile vinyl gloves and latex/nitrile gloves for contact with blood
- disposable plastic apron
- disposable face protection
- disposable paper towels
- disposable cloths
- clinical waste bag
- small container of general purpose detergent
- sodium dichloroisocyanurate compound NaDCC (eg, *Presept, Sanichlor, Haz-Tabs*) or hypochlorite solution (eg, household bleach or *Milton*). These compounds should be kept in a lockable cupboard.
- absorbent powder, eg, *vernagel* to soak up the liquid content of the spillage.

The kit should be immediately replenished after use. Alternatively, you may wish to purchase a commercially produced spillage kit.

Decontamination of reusable medical devices

Many practices do not have robust procedures for decontaminating reusable medical devices. This includes cervical specula, auroscope pieces, scalpel blade holder, scissors and forceps. Failure to comply with current primary care guidelines would make a claim difficult to defend should a patient suffer an adverse event.

Recommendation: Consider the use of sterile single use devices, which will remove the need for decontamination. If your practice uses re-usable medical devices, the decontamination process must be robust and comply with the *Code of Practice for Decontamination of RIMD* (2007).[5]

Infection Prevention and Control Guidelines for Primary Care states: "It is difficult to achieve adequate decontamination in a general practice setting…for this reason the use of single/disposable equipment is preferable."[3]

Infection control guidelines

The *Infection Prevention and Control Guidelines for Primary Care*[3] have been produced by the National Clinical Programme for HCAI and AMR (antimicrobial resistance) prevention, in collaboration with the ICGP. The guidelines provide advice for infection prevention and control in general practice and include audit tools to assess current practices and plan for future practice development and training.

Top tips for effective infection control in general practice:

1. Ensure the practice has a nominated lead responsible for infection control issues.
2. Make sure the premises are clean, with a designated person responsible for cleaning.
3. Provide accurate information for patients about infection control issues.
4. Provide accurate information on infections to all persons providing support or nursing/medical care.
5. Patients who have infections should receive appropriate initial advice and treatment.
6. All staff in the practice should receive appropriate infection control training.
7. Provide adequate isolation facilities for patients presenting with an infectious condition.
8. Secure adequate access to diagnostic, microbiology and virology laboratory services.
9. Discuss and maintain infection control policies, such as safe handling and disposal of sharps, aseptic technique, decontamination of instruments etc.
10. Ensure healthcare workers are protected from exposure to infections.

How can MPS help your practice?

MPS has developed an interactive workshop to give general practice teams a clear understanding of the importance of infection control, providing you with the skills to manage and reduce infection in your practice.

Practices may wish to complement this workshop by booking an Infection Control Risk Assessment for the practice. An Infection Control Risk Assessment involves a two to three hour practice visit by one of our expert facilitators. The risk assessment is a supportive process that is tailored to the needs of the practice, giving a very personal quality improvement experience. **www.medicalprotection.org/ireland/infection-control**

Summary

Today, patients have high expectations for their healthcare needs – particularly when it comes to healthcare providers meeting hygiene standards. A key part of achieving this is ensuring effective infection control and prevention systems within your practice.

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Minor surgery, major risks

Dr Diarmuid Quinlan, a GP with a special interest in dermatology, explores the risks of performing minor surgery in primary care

Minor surgery in primary care offers enormous benefits to patients, practices, GPs and indeed the HSE. Minor surgery in general practice fulfils the HSE mantra of "quality, access and cost".[1] GPs offer a high quality minor surgical service. This is readily accessible both in terms of waiting time (often a matter of days) and in terms of proximity to the patient's home. The costs are modest, especially compared to similar procedures undertaken in secondary care. The key issues to address are consent, training, and infection control.

"There is no such thing as minor surgery, only minor surgeons" raises a cautionary note for all those engaged in the provision of surgical services. There are pitfalls, which can be anticipated and hopefully avoided. In our constantly evolving medicolegal climate an awareness of hazards and active risk management is crucial. Make your minor surgery a "win-win" situation for patients and doctors.

What surgery?

The range of lesions treated in primary care is extensive. They vary from simple repair of uncomplicated lacerations, to GPs undertaking injections, incisions, excisions, flaps, grafts, and vasectomies. The management of skin cancer in primary care is a complex issue, complicated by the potential for suboptimal waiting times for assessment in secondary care. The management of a low risk basal cell carcinoma in a housebound elderly patient is clearly different to urgent management of a younger person with a suspected melanoma. GPs providing skin cancer care must be aware of evolving national and international guidelines, and personalise such guidance to ensure timely management of each patient.[2]

Premises

You should ensure your practice has appropriate space, lighting, and facilities to undertake minor surgery. Many doctors use magnification to enhance the cosmetic outcome. All equipment necessary for the procedure, including possible complications (eg, unexpected bleeding) should be readily available. Appropriate resuscitation facilities are crucial. Doctors undertaking suturing at sports events, remote from the GP premises, must have ready access to normal resuscitation facilities.

Training in minor surgery

This is essential. Many GPs already have extensive surgical training and use these skills to benefit their patients. Regular training helps ensure these skills are up-to-date, and may expand the range of procedures safely offered. The Primary Care Surgical Society (PCSS) lead the way, ably supported by the ICGP and Primary Care Dermatology Society. Some doctors choose to travel to the UK or further afield to obtain training and to up-skill. In the unfortunate event of an adverse outcome, such training may strengthen your defence.

Infection control

Infection control evolves and improves constantly. Comprehensive and practical advice, *Infection Prevention and Control Guidelines for Primary Care*, has been produced by the National Clinical Programme for HCAI and AMR (antimicrobial resistance) prevention, in collaboration with the ICGP.[3] Read it today. All the minutiae of infection control, from the Hepatitis B titre of the surgeon, to safe disposal of clinical waste, must be actively managed. Official guidance should be personalised to your practice. Consider completing the excellent audit tools which are part of this document – improve patient safety AND complete your audit requirement. At a minimum the operating room should have washable flooring, elbow operated taps/liquid soap/alcohol hand gel, personal protective equipment such as gloves (including latex free), masks and aprons. High quality single use disposable instruments are readily available.

Many doctors have completely discontinued "in house" autoclaving of surgical instruments. Doctors who elect to re-use instruments must ensure total compliance with current guidance.[3] Please see the section 'Decontamination of re-usable medical devices' on page 7 ("Infection control – time for a clean sweep?") for more information.

Histopathology

All specimens excised should be submitted for histological examination. Implement a robust system to ensure that a report is obtained for every specimen; "specimen out – report back". This system may be electronic or paper, but must be absolutely foolproof. Some colleagues go even further to ensure patient safety. They keep a patient file "live", until patients in whom a referral was initiated (usually for skin cancer) have actually been seen by a hospital doctor. There is much merit in this enhanced patient safety system.

Audit and minor surgery

Minor surgery provides wonderful opportunities for audit, as highlighted in April 2013's *Forum*.[4] Consider an audit of infection rates, concordance of clinical diagnosis and histology reports, adequacy of consent or patient satisfaction. This verifies quality, while satisfying our Medical Council audit requirements. The ICGP also provide an easy-to-use audit template for infection control – try it out in your practice.

Consent

How "informed" is informed consent? The adequacy of consent may come under intense scrutiny at a later date – MPS has a booklet outlining the essentials of consent.[5] The standards of yesteryear may no longer be adequate. Medical literature abounds with cases where consent was deemed inadequate. Consent is also a key part of managing patient expectation. Does your patient know that a joint injection may introduce infection, that a scar may be ugly due to keloid, or that infection is always a possibility? Do your notes unambiguously document that consent was discussed in detail? Consider developing a standard minor surgery "pro-forma". Augment this with a patient information leaflet (PIL) for the specific procedure undertaken. Such PILs are readily available online. At a minimum, the leaflets should include the nature and purpose of the procedure, alternatives (including no treatment) and more common complications. MPS recommends obtaining written consent for all procedures, including cryotherapy, joint and soft tissue injections.[5] Written informed consent should be obtained prior to the first cryotherapy session; it is prudent to discuss any patient concerns at each subsequent treatment, and document the same. My clinical IT system allows "clinical note templates", which simplify the otherwise tedious task of writing similar notes repeatedly. Talk to your IT provider.

Minor surgery in primary care is a high quality, locally accessible service provided at modest cost to patients. Like all medical undertakings it has inherent risks. Active risk management of minor surgery is not onerous. Consider the key areas of adequate training, informed consent and rigorous contemporaneous infection control in your practice.

Actively manage your risk:

- Adequate training
- Informed consent
- Rigorous infection control.

Dr Diarmuid Quinlan is a GP based in Cork and MPS clinical risk assessment facilitator.

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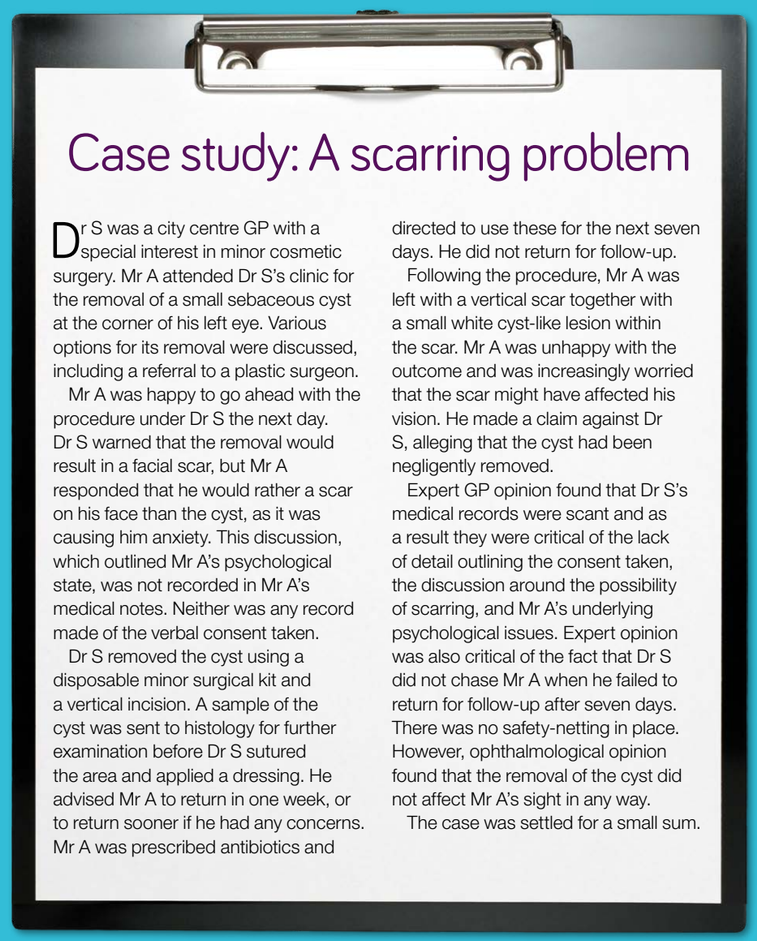

Case study: A scarring problem

Dr S was a city centre GP with a special interest in minor cosmetic surgery. Mr A attended Dr S's clinic for the removal of a small sebaceous cyst at the corner of his left eye. Various options for its removal were discussed, including a referral to a plastic surgeon.

Mr A was happy to go ahead with the procedure under Dr S the next day. Dr S warned that the removal would result in a facial scar, but Mr A responded that he would rather a scar on his face than the cyst, as it was causing him anxiety. This discussion, which outlined Mr A's psychological state, was not recorded in Mr A's medical notes. Neither was any record made of the verbal consent taken.

Dr S removed the cyst using a disposable minor surgical kit and a vertical incision. A sample of the cyst was sent to histology for further examination before Dr S sutured the area and applied a dressing. He advised Mr A to return in one week, or to return sooner if he had any concerns. Mr A was prescribed antibiotics and directed to use these for the next seven days. He did not return for follow-up.

Following the procedure, Mr A was left with a vertical scar together with a small white cyst-like lesion within the scar. Mr A was unhappy with the outcome and was increasingly worried that the scar might have affected his vision. He made a claim against Dr S, alleging that the cyst had been negligently removed.

Expert GP opinion found that Dr S's medical records were scant and as a result they were critical of the lack of detail outlining the consent taken, the discussion around the possibility of scarring, and Mr A's underlying psychological issues. Expert opinion was also critical of the fact that Dr S did not chase Mr A when he failed to return for follow-up after seven days. There was no safety-netting in place. However, ophthalmological opinion found that the removal of the cyst did not affect Mr A's sight in any way.

The case was settled for a small sum.

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CORE SKILLS SERIES

Prescribing

In this series we explore the key risk areas in general practice

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At a glance

Prescribing can be a risky business, especially when prescribing for older people or children. *Charlotte Hudson* talks about the risks and what you can do to make sure you avoid them.

Prescribing can be fraught with complications: over-prescribing, transferring incorrectly to new charts, prescribing for the wrong patient, incorrect dosages, interactions, and allergies. You should have a good knowledge of pharmacology and the legislation surrounding drugs, as well as your practice's protocols and controlled drug routines. If you are unsure, ask.

The Medical Council, in its *Guide to Professional Conduct and Ethics* (2009), states that when prescribing medicines: "You must ensure as far as possible that any treatment, medication or therapy prescribed for a patient is safe, evidence-based and in the patient's best interests."[1]

The guidance also states: "You should be particularly careful when prescribing multiple medications in case the combination might cause side-effects. You should also take particular care when prescribing for patients who may have an impaired ability to metabolise the medication prescribed. You should weigh up the potential benefits with the risks of drug adverse effects and interactions when deciding what to prescribe. This also applies to the exercise of the prescribing of generic drugs. A patient's treatment regime should be reviewed periodically."

Whether prescribing errors result in harm to patients depends on a number of factors, but certain patients are at particularly high risk and it is important to be aware of the drugs that are commonly associated with morbidity in general practice.

Risks associated with medication errors are particularly high in the following groups of patients:

- The elderly, particularly when frail
- Those with multiple serious morbidities
- Those taking several potentially hazardous medications
- Those with acute medical problems
- Those who are ambivalent about medication taking or have difficulty understanding or remembering to take medication.

With these patients, it is important to take particular care when first prescribing, to prioritise medication review, and to check for any communication issues.

Older patients

In the Irish population, 90% of those aged over 75 years take medications regularly, and one in five of those over 50 years regularly take five or more medications (ie, polypharmacy). Polypharmacy potentially puts the ageing population at greater risk of inappropriate prescribing, non-adherence and adverse drug reactions.[3]

What can you do to help?

- Help older patients with the practical aspects of drug taking – reminder charts, compliance aids (eg, a medication organiser) and specially written instructions. The physical effects of ageing, such as arthritis and failing eyesight and memory, can cause issues for older people in taking medicines the way you intended.
- Try to keep their drug schedule as simple as possible. When starting a new drug, keep the dosage low at first. The ageing body can be more susceptible to the side effects of medicines – be careful not to write off side effects of medication as the effects of ageing.
- As most prescriptions for older people are repeat prescriptions, regular review is essential.
- Monitor patients for side-effects of medications – this can help to identify problems before they result in serious patient harm.

> The most important effect of age on medication is a reduction in renal clearance. Many older patients therefore excrete drugs slowly and are highly susceptible to nephrotoxic drugs. This effect may be exacerbated by an acute illness, particularly one that causes dehydration.

Children

Children have a very different response to drugs. Special care is needed in ensuring the drug prescribed is appropriate and that the correct dosage is given, especially in the neonatal period.

This is particularly true for drugs that are started in secondary care. The *Irish Medicines Formulary* (*IMF*)[4] contains information on dosing in specific populations, including adults, children, the elderly and those with impaired renal or hepatic function.

When writing a prescription for patients under 12 years old, you are required to include the patient's age or date of birth.

Clinical Risk Self Assessments

Clinical Risk Self Assessments (CRSAs) conducted by MPS in more than 153 general practices in the UK and Ireland in 2013 revealed that more than 95% faced risks related to prescribing.

The most common risk was uncollected scripts, with more than 52% of all the practices visited having this problem, followed by more than 49% having repeat prescribing policy issues – either they didn't have a policy in place, the one they have has insufficient detail, or the one they have is not adequate.

Prescriptions should clearly identify the patient, the drug, the dose, frequency, route of administration and start/finish dates, be written or typed and be signed by the prescriber. Take care that the correct information is typed up/written down.

You should ensure that you know as much about the patient as you can, for example, being aware of and documenting a patient's drug allergies.

The most common problems with communication occur between the doctor and patient, but there are also major issues at the interface between primary and secondary care – good handovers require good leadership and communication.

You should ensure you are familiar with the side-effects and contraindications of the medicines you are intending to prescribe. You should also be aware of guidance relating to the clinical and cost effectiveness of the medicines you are prescribing.

Verbal prescriptions are only acceptable in emergency situations and should be written up at the first available opportunity. Particular care should be taken that the correct drug and dose is used.

www.medicalprotection.org/ireland/crsa

Adverse drug reactions

Adverse drug reaction profiles in children may differ from those seen in adults. You should report suspected drug reactions to the Health Products Regulatory Authority, even if the product is being used in an off-label manner or is an unlicensed product.

Advice for safer paediatric prescribing

Limit the drugs you use to a well-tried few and familiarise yourself with their dosages, indications, contraindications, interactions and side-effects. Refer to a paediatric formulary when appropriate.

If you are prescribing in very small amounts of less than 1 milligram, prescribe in micrograms (written out – not abbreviated) to avoid confusion over the placing of decimal points.

When prescribing for a child, it is particularly important to give the parents all relevant information such as:

- Name of the drug
- Reason for the prescription
- How to store and administer the drug safely (if appropriate)
- Common side-effects
- How to recognise adverse reactions.

Parents must always be warned about side-effects, particularly those that will be distressing to the child. It is also helpful to remind them of the importance of storing drugs in their labelled containers and out of the child's sight and reach.

Substance misusers

Some practices will register substance misusers for their primary healthcare needs, but leave treatment of their addiction to a local drug treatment centre. Others may get more involved, offering prescribing services, for example. Find out what the arrangement is in your practice.

The Medical Council, in its *Guide to Professional Conduct and Ethics* (2009), states: "You should ensure you have appropriate training, facilities and support before treating patients with drug dependency or abuse problems."

It also states: "You must be aware of the dangers of drug dependency when prescribing benzodiazepines, opiates, and other drugs with addictive potential."

> Read more on safe prescribing in our factsheet: *Safe prescribing*: **www.medicalprotection.org/ireland/factsheets/safe-prescribing**

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1. Medical Council, *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (2009) www.medicalcouncil.ie
2. Medical Council, *Talking About Good Professional Practice* www.medicalcouncil.ie
3. TILDA, *Polypharmacy in Adults Over 50 in Ireland: Opportunities for Cost Saving and Improved Healthcare* (2012) http://tilda.tcd.ie
4. *Irish Medicines Formulary* www.formulary.ie
5. NPC, *10 top tips for GPs: Strategies for Safer Prescribing* (2011) www.npc.nhs.uk

The UK's National Prescribing Centre (NPC), in *10 Top Tips for GPs – Strategies for Safer Prescribing*,[5] advises:

1. Keep yourself up-to-date in your knowledge of therapeutics, especially for the conditions you see commonly
2. Before prescribing, make sure you have all the information you need about the patient, including co-morbidities and allergies
3. Before prescribing, make sure you have all the information you need about the drug(s) you are considering prescribing, including side-effects and interactions
4. Sometimes the risks of prescribing outweigh the benefits and so before prescribing think: 'Do I need to prescribe this drug at all?'
5. Check computerised alerts in case you have missed an important interaction or drug allergy
6. Always actively check prescriptions for errors before signing them
7. Involve patients in prescribing decisions and give them the information they need in order to take the medicine as prescribed, to recognise important side-effects and to know when to return for monitoring and/or review
8. Have systems in place for ensuring that patients receive essential laboratory test monitoring for the drugs they are taking, and that they are reviewed at appropriate intervals
9. Make sure that high levels of safety are built into your repeat prescribing system
10. Make sure you have safe and effective ways of communicating medicines information between primary and secondary care, and acting on medication changes suggested/initiated by secondary care clinicians.

Dr John Paul Campion, a GP registrar from Mid Leinster, contemplates his future as a fully qualified GP

As I write this, I am in my final week as a GP registrar. My apprenticeship is coming to an end and I will emerge to become a fully qualified GP. It is probably the most frightening time of my career. Up to now I have had the security of HSE employment on a fixed-term contract. I have been nobody's boss and I have had little in the way of responsibility. The step up is a daunting one, but I feel ready for whatever challenges come my way.

The current economic and healthcare climate is very frightening too. The amount of uncertainty in the whole system is making definite career planning a virtually impossible task. What I do know is that I want to stay in Ireland. That used to be a given for Irish GP graduates, but now there is an exodus to foreign shores unlike anything experienced in the healthcare profession before. We are losing so many GPs to better pay and conditions in Canada, Australia and the Middle East on a weekly basis that it seems there will soon be nobody to inherit Irish general practice.

I know that long term, I want to be my own boss, and within general practice that means being a principal someday. That means waiting for the right opportunity to arise. I'm going to be working as a sessional GP for the short term and see where it takes me but ultimately I see myself with my own practice.

That's where the uncertainty lies. Where is the future of general practice heading? Will the current model of mixed GMS and private be sustainable in the future? Will FEMPI cut more meat from the already skeletal GP incomes? Will the new GMS contract be as bad as we all fear it may be? How can I find a locum, or will I just never be able to take a holiday again? It's like standing on the edge of a pool and not knowing how deep the water is.

I am optimistic about the future despite all the doom and gloom. The health system needs general practice. It needs it to function well. It needs GPs who are invested in their communities and who can deliver efficient and effective medicine at the real frontline. Change is inevitable. General practice will transform drastically over the coming years, business models will evolve and some will adapt better to these changes than others. I won't fear to jump into the health system feet first, because I know that I have been well trained and that my options are still there no matter what happens. It's time to step over the edge.

Test your knowledge

Try out the mock questions below and test your knowledge on the topic of prescribing

1. Last thing on a busy Friday evening the practice nurse asks you to write out a prescription for diazepam for Mr Johnson. You:

A. Sign a blank prescription form for the nurse to fill in the details.

B. Write a prescription immediately.

C. Check Mr Johnson's notes, and possibly see him yourself, before prescribing.

2. A patient comes into the surgery and requests that you prescribe them a drug they have seen on the internet. It is not licensed in Ireland. What is the most appropriate response?

A. Refuse immediately, recording the reasons why in the patient's notes.

B. Consider the request. You can prescribe unlicensed medicines, but you must be satisfied that there is no alternative, licensed medicine to meet the patient's needs.

C. Say yes, once you have checked with the senior partner.

3. You are having headaches that you associate with migraine. What should you do?

A. Write yourself a prescription to take to the pharmacy after work.

B. Make an appointment to see your own GP.

C. Ask your GP trainer to write you a prescription.

Answers: 1C, 2B, 3B.

I've finished training, what's next?

Dr Peter A Sloane, Director of the ICGP's Network of Establishing GPs (NEGs), discusses the career options for newly-qualified GPs

At the outset of GP training, four years seems like an eternity. The only consideration is to get stuck into becoming a GP. Few trainees think beyond the training post they are doing, their next exam, or their pending presentation, piece of research, or audit – training is a very busy place to be.

Sometime during fourth year, the reality of needing to find work sinks in. While there are always a few who already have jobs lined up, that isn't the case for most trainees. I remember it well from my fourth year: that dawning realisation that I would no longer have a regular HSE salary and that the EFT payment wouldn't automatically be in my bank account.

I'm not sure many trainees will believe me, but more than two years later I've never actually had to look for work, have found myself working more than I'd like, and have lost the fear of being unable to find work. Despite all the economic doom and gloom and the uncertainty facing general practice, the truth in Ireland right now is that we face a shortage of GPs and in particular GP locums. In hindsight, I really needn't have worried so much about finding work.

So, the questions arise: How do you find work? What are the options? What support, if any, is available? And ultimately, how do you lose the fear of not finding work?

The first and most important aspect of finding work is to be aware of the possibilities and to be prepared. Assuming you wish to remain in general practice (as there are always a few who opt to go back to hospital medicine), there is actually a defined set of steps which you can take to be prepared.

Firstly, it is imperative to prepare a good CV. It is best if your CV is clear, concise and easily legible with all information on one side of A4 paper. At the top, include basic details (name, Medical Council number, indemnity details, telephone number, and email), and below, share succinct information under clearly laid out headings of clinical career history, education and qualifications, clinical skills qualifications, and any relevant management/leadership experience. Referees, usually three, should be listed, having first obtained their permission. Whilst it is tempting to list other achievements and information (such as interests, hobbies, etc) this information is superfluous.

Secondly, you must disseminate your availability to work as widely as possible. This can be done through word of mouth or in writing to GPs, practice managers and practice secretaries in the geographical area in which you want to work, with local out-of-hours GP co-ops or corporate GP enterprises, by placing a free advertisement on the ICGP classifieds, via GP training schemes' email lists, or by placing advertisements in the medical press classifieds.

Thirdly, you should become familiar with and regularly check the many places in which work is advertised or made known. This will again include through word of mouth (on the GP "grapevine", small group CME, local Faculty, training schemes, clinical societies), on the ICGP classifieds, on the NEGs discussion boards and other online discussion fora, via GP training programmes, and in the classifieds section of the medical press. Advertisements for GMS lists can also be found on the HSE website.

In the immediate post-training period any work is usually gratefully accepted; however, with time and experience it is likely that you will become more discerning. Most often, GPs directly out of training schemes start off doing short term locum work, ie, a few days here and there or covering a week or two leave. It is possible to do out-of-hours shifts in conjunction with this, through various sources including GP co-ops. Corporate primary care centres may also seek locums. Locum work for longer periods may be an attractive option, eg, four or six month posts. Such work may lead to sessional work or assistantship, with or without a view to partnership. It is of course possible to find longer term locum work, a sessional position, or an assistant position directly from a training scheme. These have the advantage of providing stability of work and income. Other work possibilities include clinical screening (eg, HeartAid), in emergency departments, with the Gardaí, prison service or department of justice, in sexual assault treatment units, with young offenders, and in family planning clinics.

In relation to support, ICGP NEGs is open to all those who have completed GP training in Ireland and seeks to provide a loose collegiate network of support and practical advice.

Combined with the type of information contained in this article, ICGP NEGs aims to give pragmatic guidance and tips as well as reassuring new GPs that there will be work for them.

From the case files…

An unusual request for disclosure

MPS medicolegal adviser *Dr Sonya McCullough* offers advice on what to do if a patient requests their records for assisted suicide

Dr M telephones the advice line:

"I am a general practitioner in a rural practice. One of my private patients, Mrs B, is recently widowed. She has just been diagnosed with terminal cancer. I have been treating her for depression and she has been attending a psychiatrist. She has confided to me that "*life is no longer worth living*" and that she intends to travel to Switzerland to a Dignitas Clinic. She wants me to provide her with a copy of her medical records for this purpose. What are my ethical obligations? What should I do?"

In line with the Medical Council's *Guide to Professional Conduct and Ethics*, patients are entitled to receive a copy of their medical records, provided that this does not put their health (or the health, safety or privacy of others) at risk.

This right of access is provided in the Data Protection Act 1988 and 2003 and the Freedom of Information Act 1997 (FOI Act).

If a patient is treated privately, as in the case of Mrs B, the Data Protection Act applies. The Data Protection Act states that health data (personal data relating to physical or mental health) shall not be supplied to a data subject in response to an access request if it would be likely to cause serious harm to the physical or mental health of the data subject.

In this case, Mrs B wants to access her records with the aim of travelling to Switzerland to commit suicide. Dr M is therefore entitled to send Mrs B notification of a refusal of a request. This must be in writing and must include a statement clearly outlining the reasons for the refusal. Dr M must also make Mrs B aware that she may complain to the Data Protection Commissioner (the "Commissioner") about the refusal.

If Mrs B does complain, and the Commissioner takes the view that Dr M is not complying with the Data Protection Act, he/she can serve Dr M a written notice, requiring him to comply with the access request and release Mrs B's records. In this case, it would be an offence for Dr M not to comply with such a notice without reasonable excuse.

In the case of public patients, an application for disclosure would be made under the FOI Act. Whilst the doctor holds the patient's notes, the HSE would be considered the "public body" under this legislation and the HSE is ultimately responsible for assessing a disclosure request under the FOI Act. A doctor should furnish the notes to the HSE, along with any comments. The HSE would then make the final decision regarding disclosure.

The FOI Act deals with a request relating to a record of a medical or psychiatric nature. If the public body concerned is of the opinion that disclosure of the information might prejudice the individual's physical or mental health, well-being or emotional condition, the decision may be made to refuse to grant the request.

However, if the request is refused, the FOI Act provides for the releasing of such records to a health professional having expertise in relation to the subject matter of the record, as the patient may specify. This can mean that the information could be indirectly released to the patient.

If the FOI Office decides not to grant the request, the decision is firstly subject to internal review in the hospital. Subsequently, the decision can be reviewed by the FOI Commissioner. The decision of the FOI Commissioner is binding. However, there is a right of appeal to the High Court.

In summary:

We would advise Dr M not to release Mrs B's records in the first instance, given that he is aware that she is intent on committing suicide in Switzerland.

Mrs B has the right to complain to the Commissioner and the Commissioner may require Dr M to comply with the request. If this occurs, Dr M may then consider it appropriate to release the records, on the directions of the Commissioner.

Remember, if you are in doubt, contact MPS for case specific advice.

What makes a patient safety culture?

MPS Clinical Risk Programme Manager *Julie Price* discusses how to build a patient safety culture in primary care

Everyone can think of a successful team: whether it be rugby, football, or cricket. But what characteristics do successful teams have to make them a winning combination?

How does good team-working translate into general practice? It is striving together for high quality and a safe service. Quality starts with safety – let us not forget the Hippocratic principle: "First, do no harm". How do you achieve this? Your practice may have fantastic individuals, but to meet these aims you must have a team safety culture.

What is a safety culture?

Safety within an organisation is dependent upon its safety culture. This concept was first coined by the nuclear power industry in the aftermath of the Chernobyl accident in 1986. Following an error during the testing of a reactor, a radioactive cloud was discharged which contaminated much of Europe – an estimated 15,000 to 30,000 people died in the aftermath.[1]

Of course, first thoughts are to blame the plant operators – they made a mistake – but as with most disasters when things go wrong it is rarely because of a single isolated event. Errors and incidents occur within a system and usually there is a sequence of events that occur before an accident happens. With Chernobyl, investigators found that the disaster was the product of a flawed Soviet reactor design coupled with serious mistakes made by the plant operators. It was a direct consequence of Cold War isolation and the resulting lack of any safety culture.[2]

For example:

- The reactor was operated with inadequately trained personnel.
- The team was not competent to do the job; they were electrical engineers rather than specialists in nuclear plants.
- There was poor communication between the team and managers.
- The nuclear reactor was housed in inappropriate premises.

The Advisory Committee on the Safety of Nuclear Installations 1991 stated that: "The safety culture of an organisation is the product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour that determine the commitment to an organisation's safety management."

Developing a safety culture

This learning can be translated into the context of healthcare. A safety culture in primary care can be described as possessing the following characteristics:[2]

- Individuals and teams have a constant and active awareness of the potential for things to go wrong.
- A culture that is open and fair and one that encourages people to speak up about mistakes – being open and fair means sharing information openly with patients and their families balanced with fair treatment for staff when an incident happens.
- Both the individual and organisation are able to acknowledge mistakes, learn from them and take action to put them right.
- It influences the overall vision, mission and goals of the team or organisation, as well as the day-to-day activities.

The systems approach to safety acknowledges that the causes of a patient safety incident cannot simply be linked to the actions of the individual staff involved. All incidents are also linked to the system in which the individuals are working.

What should you do to build a safety culture?

- Undertake a baseline cultural survey of your practice
- Undertake a risk assessment to identify potential risks to patients and staff
- Appoint a risk manager for the practice
- Develop effective leadership, ie, lead by example, and demonstrate that you are sincerely committed to safety
- Encourage team working – build ownership of patient safety at all levels and exploit the unique knowledge that employees have of their own work
- Develop a structured approach to safety
- Ensure effective communication with the team and patients
- Learn lessons from complaints and mistakes – remember we will all make mistakes (to err is human) but the key is to learn from those mistakes and ensure that systems are robust so that errors are less likely to happen
- Ensure that staff are trained to competently undertake the roles assigned to them.

Is your practice safety culture up to scratch?

Changing your practice culture and increasing staff awareness can make a positive and measurable difference to patient safety.

MPS's Safety Culture 360 is a unique validation tool which covers four key areas of patient safety. It brings practice staff together to understand and enhance the safety culture within your practice.

Take our online survey today and benchmark your practice against the 850 that have already taken part.

To learn more, follow this link: **www.medicalprotection.org/pmirl/360**

Summary

The correlation between safety culture and patient safety is dynamic and complex. Healthcare is not without risks and errors and incidents will occur. General practice should work to minimise those risks by ensuring systems are robust and that when things do go wrong, lessons are learnt and appropriate action is taken. By developing a team approach to patient safety it will in turn develop the safety culture of your practice and improve the quality of care provided.

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1. *World Nuclear Association Chernobyl Accident* 1986 (2009)
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