



Digital dilemmas

Texting patients and patients
recording consultations

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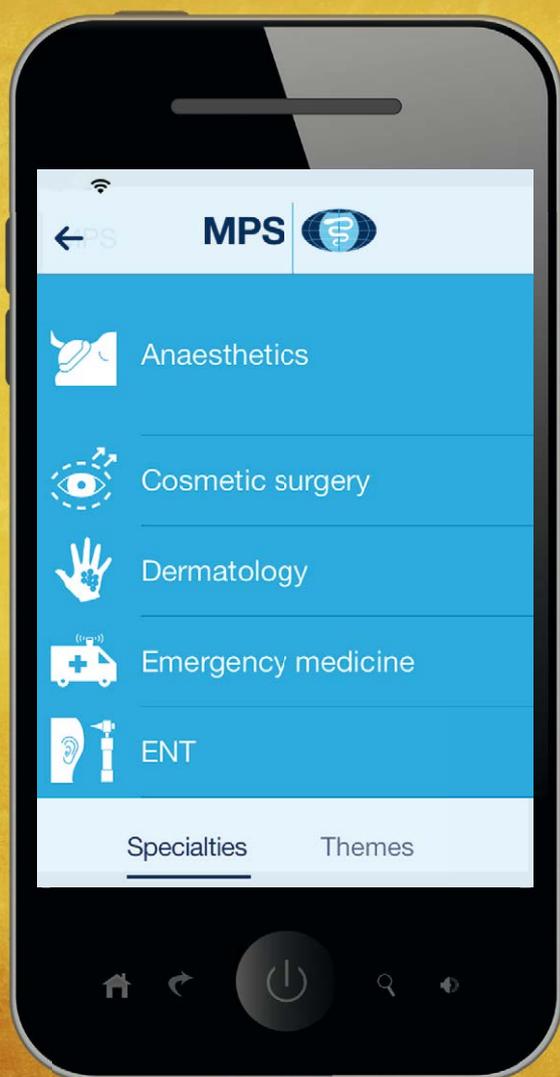


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Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

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Welcome



Dr Richard Stacey
Editor-in-chief and MPS medicolegal adviser

The team at *Practice Matters* select articles based on what is topical with MPS practice members. We regularly review the queries to the MPS telephone advisory service in order to draw out what is topical and relevant.

So-called digital dilemmas are frequently the subject of calls taken by medicolegal advisers such as myself.

In this issue we tackle dilemmas around communicating with patients by text and patients asking to record a consultation. Tackling the former first, text messaging is an easy and direct way of communicating information, such as test results, however, practices must be mindful of the risks around confidentiality and consent that it could present.

A key factor to remember is that text messages do form part of the medical record and any text message exchanges should be recorded therein.

Recording consultations should be handled differently; if you feel uncomfortable at the prospect of being recorded, express this discomfort with the patient.

However, if the patient is insistent, you still owe a duty to the patient to assess their condition. It is advisable that if the consultation is recorded; keep a copy of the video in the patient's notes as part of a permanent record.

Flexibility and technological advances are part of the future of general practice, so it is worth considering that recording consultations, with both patient and GP retaining copies as records, could be commonplace in the future. It is necessary to consider the risks now.

As always, I hope you enjoy this edition. Please do feedback any comments you may have.

Richard Stacey

A round-up of the most interesting news, guidance and innovations



Doctors who harm patients to face tougher sanctions, GMC proposes

MPS is preparing a detailed response on behalf of doctors in reply to the GMC's latest proposals for doctors who cause harm to patients, through professional misconduct or clinical error, to face sanctions even if they can demonstrate that their practice has improved.

This consultation is part of the GMC's proposed changes to the indicative sanctions guidance it provides to fitness to practise hearing panels run by the Medical Practitioners Tribunal Service.

GMC chairman Niall Dickson said: "Doctors are among the most trusted professionals, and rightly so, and they deserve to be treated fairly. In the vast majority of cases one-off clinical errors do not merit any action by the GMC. But if we are to maintain that trust, in the small number of serious cases where doctors fail to listen to concerns and take action sooner to protect patients, they should be held to account for their actions."

The GMC is consulting on:

- Imposing sanctions where doctors make serious clinical errors, even where they have successfully retrained and improved their practice, if they failed to heed concerns and take steps to protect patients sooner.
 - Whether panels should require a doctor to apologise where he or she has previously failed to do so.
 - Imposing more serious action in cases where doctors fail to raise concerns about a colleague's fitness to practise or take prompt action where a patient's basic care needs are not being met.
 - Improved public protection in cases where a doctor has bullied colleagues and put patients at risk or discriminated against others in their professional or personal life.
- MPS is currently examining the proposals in detail and will be formulating a response on behalf of doctors, which is due for publication later this year. Source: *Pulse, GMC*

Recording female genital mutilation in records

All clinical staff must record that a patient has undergone female genital mutilation in their records, according to the Department of Health. A full list of requirements can be found in the DH's *Recording FGM. How the New Rules Affect General Practitioners*. MPS has produced a factsheet to support practitioners in this area: www.medicalprotection.org/uk/england-factsheets/female-genital-mutilation.



Online access could cut appointments

Giving patients online record access could cut pressure on appointments, according to research published in the *London Journal of Primary Care*. The research suggested that if 30% of patients accessed their electronic general practice record online at least twice a year, a 10,000-patient practice is likely to save 4,747 appointments and 8,020 telephone calls each year – about 11% of appointments. Source: *London Journal of Primary Care*





A new criminal offence for doctors

Brought to you by the MPS Policy team

Despite MPS lobbying, the government has pushed ahead with its proposals to introduce a new criminal sanction of ill-treatment or wilful neglect and the measures are now in a Bill before parliament.

Criminal investigations looking into matters of clinical practice, or the use of resources, would be inappropriate and highly disruptive as well as stressful for staff. We know that criminal investigations, no matter if they end up with a case being brought or not, create an atmosphere of fear that has repercussions on a culture of openness.

MPS is concerned that in recent years there has been a growing trend towards introducing new laws and regulations to influence the behaviour of healthcare professionals. Placing ever more regulatory burdens on doctors is not, in MPS's opinion, the best way of driving an open learning culture in healthcare or improving patient safety. Mentoring and leadership from the top, alongside education and training, are the most effective ways of ensuring high quality patient care and a profession that feels able to report mistakes.

We have worked closely with a group of healthcare organisations to call on Jeremy Hunt, the Secretary of State for Health, to introduce safeguards to be added to the Bill, which aim to ensure that doctors are not subjected to unwarranted investigations that waste time and money. Whatever the response, we will continue to lobby on the Bill to minimise the negative impact for members.

HOT TOPIC

Better care for older people

Professor Sir Peter Rubin, Chair of the GMC, discusses the GMC's latest campaign and online resource



Older patients have told us they don't want to be treated differently because of their age. They want to be treated as individuals, feel they are being listened to by their doctor and have the opportunity to ask questions. We want everyone to receive good care and this is why we are working in partnership with organisations such as the British Geriatrics Society and Age UK to ensure that older patients receive the care they deserve.

To achieve this we have produced a new online resource to support doctors caring for older people. The resource gives practical advice showing how existing GMC guidance can be used to support doctors. It includes interactive case studies, articles and tips to prepare doctors for caring for the growing numbers of older patients. There are in fact currently 15,000 people in the UK aged over 100 and the over 65s make up over two-thirds of NHS patients.

The content will be regularly updated with fresh topics and personal perspectives from

leading clinicians and others working in the field. One article by Dr Adam Gordon of the British Geriatrics Society reflects on a recent experience that shows the importance of involving a person's family and carer in decisions about their end-of-life treatment.

www.gmc-uk.org/guidance/25031.asp

Doctors can also download a reflections record. This will help them to think about what they have read and identify specific areas of skills and experience they may want to improve when treating older people. Doctors can use this for their appraisal and revalidation portfolios.

We welcome people's feedback on the resource and if there is information you would like to see included make sure to let us know. We want to make it as useful to doctors as possible so please send us your suggestions and comments via the website and help us to support doctors to give the best possible care to older patients. www.gmc-uk.org/guidance/23756.asp

Events

MPS "Mastering" series of workshops

The MPS "Mastering" series are designed to help members improve their communication skills and avoid problems.



When: Various

Where: Across the UK

Medical Records for GPs Workshops

These workshops focus on creating a strong and resilient general practice for the future.



When: Throughout the year

Where: Exeter, Liverpool, Edinburgh, Leeds, London

Management in Practice

The theme is 'Futureproof: resilience in practice'. How can we or how are we working towards strong, resilient general practice for the future, providing the best possible practice and outcomes for patients?



When: 16 Oct 2014

Where: London

MPS HR and Employment Law Seminars

These half-day seminars are aimed at practice managers, giving them the tools to tackle HR.



When: 22 Oct and 19 Nov 2014

Where: Manchester, London

MPS Practice Management Seminars

Focusing on patient safety and complaints, these seminars are practical and interactive.



When: 12 Nov and 3 Dec 2014

Where: Edinburgh, Nottingham

Digital dilemmas

MPS advisers answer real dilemmas from the advice line

Communicating with patients by text

We want to start communicating with patients by text, what should we be mindful of?

Dr Richard Stacey, MPS medicolegal adviser, shares his advice

There is no reason why you shouldn't embrace the benefits of communicating in this way, but you should be mindful of the pitfalls around consent and confidentiality that it presents. For example, patients may change their mobile number, or their friends and/or family could read the message.

You should also bear in mind that text messages do form part of the medical record and any text message exchanges should be recorded therein. They are also not an appropriate way to deal with complex clinical queries.

Here are two scenarios that demonstrate the pitfalls of communicating by text message even when reasonable safeguards have been put in place.

Why are you texting my daughter?

In the middle of a busy Monday morning surgery, Dr J consulted with patient C, a 17-year-old student. C was distraught because several weeks previously she had had unprotected (consensual) intercourse with her 17-year-old boyfriend and her period was now late.

Dr J explained that she would arrange a urine pregnancy test and C agreed to bring in a sample the following morning. C specifically asked Dr J if she would arrange for the practice to send her a text when the result was available as she was currently in the middle of her A-level examinations and as a consequence may not be immediately contactable by telephone. Dr J agreed to this request, took C's mobile number and documented her consent clearly in the records.

C's pregnancy test was subsequently returned as being positive and in accordance with her request she was sent a text message which read: "Please contact the surgery".

Several minutes after sending the text the surgery received a call from C's father who explained that C was currently sitting an A-level examination, and had left her mobile at home so he had picked up the text.

C's father was anxious to know why she had been asked to call the practice.

Advice

- Although the practice was able to maintain C's confidentiality while keeping her father on side, the dangers

of communicating by text message are evident.

- Fortunately, Dr J confirmed and documented C's consent. The text message C received did not reveal the fact that C had undergone a pregnancy test, nor did it reveal the result.
- When communicating with patients by way of text message, you should always be mindful of the fact that persons other than the intended recipient may have access to the message.

The wrong mobile number

Mrs B, a 44-year-old management consultant, attended Dr S's emergency surgery asking for a sexual health check. She admitted that she had been having an affair with a colleague. The affair was now over and she believed she may be at risk of chlamydia.

She told Dr S that her relationship with her husband was currently very strained. She did not want her husband to know that she had attended the surgery.

Dr S carried out a speculum examination to obtain swabs. Mrs B asked Dr S to text her the results of the tests as she was going to be traveling on business for the next ten days and didn't want a letter sent or a message left on the house phone. Dr S looked on the screen to check that she had a mobile number for the patient and agreed to her request.

Three days later the result came back that Mrs B was positive for chlamydia. Dr S sent a message to Mrs B which read

"Test positive: please contact surgery". One hour later an irate Mr B was at the desk, stating that he had received the message on his mobile phone.

Dr S apologised that the text was sent in error, but gave no further details. Mr B had had a recent hypertension review with the practice nurse and had asked her to update his mobile number. The nurse was new to the practice and inadvertently accepted the computer's prompt to update all the household members' contact details with the new mobile number.

Later that day a distraught Mrs B telephoned Dr S. Her husband had contacted her and she had admitted the affair to him. She subsequently made a written complaint to the practice that her confidentiality had been breached by text.

Advice

- Changes to contact details are best undertaken by administrative staff (rather than clinicians in a consultation), in accordance with practice protocols.
- Clinicians should double-check contact numbers for patients if they are going to contact them by text for a specific result.
- Ensure that default settings on computer systems are for individual telephone numbers and not for all household members.

Useful links

- GMC; *Confidentiality* (2009)
- MPS factsheet, *Communicating with patients by text message* (2014)



Patients recording consultations

A patient asks to record my consultation on their smartphone – What should I do?

Dr Nick Clements, MPS head of medical services (Leeds), shares his advice

It is becoming common for patients to ask to record a consultation on their mobile phones about a proposed treatment or condition. MPS has also seen cases where patients are not seeking consent and are making covert recordings. In a recent case in the USA, doctors were sued after a patient's mobile phone recorded them having an unprofessional conversation about the patient whilst he was under anaesthesia.

So what should you do if a patient asks to record a consultation with you? It is common courtesy that somebody wishing to make a recording should ask permission. If you feel uncomfortable at the prospect then you should express that discomfort and tell the patient that you would prefer the consultation not to be recorded.

If you would prefer not to be recorded, but the patient is insistent, you still owe a duty to the patient to assess their condition and offer any necessary treatment. It would be inadvisable for you to refuse to proceed with a consultation because the patient wishes to record it, otherwise the patient might come to harm if they were suffering from a serious or urgent condition.

If the consultation is recorded, it would be sensible to ask for a copy so that it can be placed in the patient's notes to form a permanent record. Modern medical records are in a variety of formats, including text messages and emails to and from patients, and recordings could become part of this mix.

Secret recordings

Technology makes it increasingly easy for patients to secretly record consultations. Most mobile phones and smartphones

have record functions which can easily be activated without a doctor or nurse realising. Even hand-held games consoles can record conversations.

A patient does not require your permission to record a consultation. The content of the recording is confidential to the patient, not the doctor so the patient can do what they wish with it. This could include disclosing it to third parties, or even posting the recording on the internet. So what does this mean for doctors?

Protection

Smartphone use in the consultation room should not affect the way you deliver your care. Doctors should always behave in a responsible and professional manner in consultations and consequently, any recording will provide concrete evidence of that. Such a record would inevitably be more complete than a traditional note and MPS experience is that detailed record keeping is an invaluable tool in protecting doctors against unsubstantiated complaints or legal action.

A recording would potentially provide

even more detail to support the doctor's professional position. There should be no reason therefore why you should have anything to fear from such a recording.

Whilst doctors may understandably feel that being recorded during a consultation may impair the doctor-patient relationship, this may well simply be a matter of adapting to current cultural and societal norms where it is becoming commonplace for the public to record and publish on the internet all sorts of pictures, recordings, etc, relating to their private lives.

Many will remember similar concerns being expressed when computer systems were first being introduced in general practice – that they were intrusive, inhibited communication and adversely affected the doctor-patient relationship. However, they are now an accepted part of general practice.

The future?

Technological advances will undoubtedly bring further changes and it may well be that in 20 years' time, recording of consultations, with copies being held by both doctor and patient, will be commonplace.



Are you social media savvy?

What happens on tour stays on tour, but what happens on Twitter stays on Google forever. Practices should be cautious when posting on social media sites, says web editor *Jack Kellett* and MPS medicolegal adviser *Dr Rachel Birch*

Social media is here to stay; once dismissed as a digital fad, it has exploded, embodying a far broader representation of society.

There have been cases where social media has been used positively to promote healthcare, such as the much popularised story of Stephen Sutton's battle with cancer. Although tragic, the updates and honest accounts from Stephen were incredibly heartwarming, and gave patients a real insight in to how healthcare is delivered to the terminally ill.

However, it would not have been appropriate for Stephen's treating doctors to post on social media about Stephen without his consent, as it would have breached his confidentiality. This

may seem obvious to experienced health professionals, but MPS receives regular calls about social media dilemmas from practice staff. A couple of scenarios include patients identifying themselves in nameless comments on social media and inappropriate comments made by practice staff.

In response to this wide tide of complaints, the GMC issued guidance around social media. *Doctors' use of social media* (2013) can be applied to any social media network, with the underlying message that the standards expected of doctors do not change because they are communicating through social media rather than face to face.



#Case_1

Dr A, a GP Registrar, wrote on Facebook that she was in close proximity to people using drugs. She joked that she may have attended work whilst affected by such substances after her numerous nights out. Her comments were picked up by another member of the practice, who alerted the practice manager. The practice manager organised a meeting with her GP trainer and she faced internal disciplinary proceedings.

Advice

Dr A's attitude and subsequent actions could have put patient safety at risk and brought the profession into disrepute. Her practice would have had no choice but to investigate her actions.

#Case_2

Following the death of a patient, Nurse S engaged in a conversation with Dr B on his Facebook wall about what happened. The conversation was brought to the practice's attention and both practitioners faced internal disciplinary proceedings.

Advice

Most social networking sites have limited privacy settings. Although Nurse S did not identify the patient by name, practice or treatment, the fact the patient could have identified themselves meant that Nurse S and his colleague had breached patient confidentiality.

It is important not to share identifiable information about patients, even when using professional blogging sites, which are not accessible to the wider public.

#Case_3

While working as a receptionist, Mrs G wrote a blog about her experiences. Although all of her posts were anonymous and she made up a lot of her stories, her practice was unhappy with her comments as it identified key members of staff within the practice. She was called into a meeting with her practice manager and the matter was investigated.

Advice

Before setting up a blog tread cautiously and consider all the following pitfalls: breaching patient confidentiality; defamation; breach of contract – your practice may not be happy with what you have to say, as was the case with Mrs G. It would have been sensible for Mrs G to obtain the permission of the practice management before she created the blog.

Inappropriate comments

Social media sites blur the boundary between an individual's public and professional life – many indecent posts that have landed healthcare professionals in trouble are the result of a perceived lack of understanding when it comes to the privacy settings on their accounts.

In 2012 a surgeon updated his Facebook status when he finished work. He wrote: "Back and causing chaos. Been on call this week. Been in theatre... slaughtering the innocent." His comments were flagged to the wife of a patient who died while under his supervision. She was understandably distressed and made a complaint to the health board. The surgeon was disciplined and forced to issue a public apology to the family.

Consequences

An ill-advised post does not simply bring an your reputation into question; it subsequently impacts on the reputation of the health profession as a whole. Your CCG or health board will take an equally dim view of you posting less than flattering comments about patients – it's safer to exercise caution. It is worth noting that defamation law can apply to any comments posted on the web made in a personal or professional capacity, so think before you tweet.

What next?

In the future we may see practices impose stricter policies on appropriate usage, but for now you should follow the GMC's guidelines on how to use social media professionally and responsibly.

Another area for you to consider is the popularity of newer networks, such as Instagram and Vine that focus specifically on alternative forms of media like photos and video. This may cause further misunderstanding as to what is perceived to be a breach of confidentiality.



GMC Chairman Professor Sir Peter Rubin on the GMC's stance on social media

Since publication, there's been lively debate on the particular piece of guidance that states if we're identifying ourselves as doctors in online discussions about health issues, we should say who we are, just as we normally do when writing to the correspondence columns of newspapers.

I want to stress that this isn't a requirement: no-one is going to get struck off for failing to reveal their identity. The GMC isn't concerned with what doctors tweet about food, fashion or football, and we acknowledge that everyone has a right to remain anonymous in their private life, outside practice. But by its very nature – social media is anything but private.

Declaring we're doctors adds weight and credibility to our views. With that privilege comes a responsibility not to undermine public confidence in the profession, whether we're discussing waiting lists or transfer lists. The GMC isn't out to curtail anyone's freedom to express their opinion on medical issues; a large part of *Good Medical Practice* is about better engaging with colleagues and patients, and better reporting of problems – something we all need a timely reminder of in light of the Francis report.

But I would suggest that a social network is not the place to raise a concern. If doctors with concerns find it hard to speak up locally they can contact our confidential helpline (0161 923 6399). If we're going to get the best for patients, particularly in financially constrained times, we need to embrace digital technology and use it to our advantage. Reading *Good Medical Practice* and using it to guide the professional judgments we make every day will help us do that.

USEFUL LINKS:

1. GMC, *Doctors' Use of Social Media* (2013) www.gmc-uk.org/guidance/ethical_guidance/21186.asp
2. GMC, *Good Medical Practice* (2013) www.gmc-uk.org/guidance/good_medical_practice.asp

How to manage online feedback

GPs are the most discussed group on NHS Choices; here are some tips to use patients' comments to your advantage

GP practices are still profoundly uncomfortable with the existence of 'TripAdvisor'-style feedback services, such as NHS Choices and iwantgreatcare.org. Anyone searching online for a practice in their area will see reviews on most local listings sites, such as Yell and Qype. Even Google itself offers its own review facility alongside its search results. However, one thing is clear – they are here to stay.

Many GPs have dismissed 'review' websites as a platform for whingers, arguing the feedback is not valid because it is not representative of the majority view and only those who have had a terrible experience are motivated enough to comment.

It is fair to say online feedback attracts the extremes at both the positive and negative end. But there is a lot practices can do to minimise the damaging effect of the odd negative comment and make feedback services work for them.

Promote feedback to patients

This can be as simple as mentioning to patients that they can review the practice online or elsewhere or putting up a poster in the waiting room. The more technologically-minded could display feedback on their own website, alongside a link to where people can leave their own, or even use social media services such as Twitter or Facebook to highlight reviews.

Take control

Promoting feedback services gives practices some control over the feedback that is left as they can target people who are regular users of their services and more likely to leave a balanced review.

Use criticism to improve practice

It is also important that practices listen to what is being said and use criticism to help them improve. No organisation gets everything right every time. Even if your patient survey results showed 95% satisfaction that still means roughly one person in every surgery has left the practice feeling unhappy with their experience. And they are the ones most likely to leave an online review.

Practices should be honest with themselves and if issues come up more than once, the chances are it is something they could improve on. The best reviews often come from initially disgruntled patients who are pleased the practice has listened and made the improvements they asked for.

Reply to all feedback

A good reply should deal with any issues raised by the person who left the original comment. People generally have a high opinion of GP practices, so will instinctively distrust online reviews that do not appear fair or balanced.

A good reply from the practice to a review that is bad tempered or not coherent will further detract credibility from that review. If a practice does not feel it can deal with the issues raised, whether because of confidentiality or because no-one can recall the events described, say this honestly and invite the commenter to visit the practice to discuss it. Leave a name and contact number at the end.

In summary, those practices that spend a little time to really engage with feedback, promote these services to patients and use the results to improve, will be the ones who set themselves apart.

What makes a patient safety culture?

MPS clinical risk programme manager *Julie Price* discusses how to build a patient safety culture in primary care



Safety Culture 360°

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 that 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/360

www.medicalprotection.org/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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Controlled drugs

With the ever-changing legislation surrounding the management of controlled drugs, clinical risk manager *Kate Taylor* asks, is your practice up-to-date?

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The repercussions of the Harold Shipman inquiry saw the introduction of tougher measures to ensure the safe management of controlled drugs (CDs). The Health Act (2006) gave inspection power to the police, who can now enter practices and inspect CD registers.¹

Practices must ensure that they are compliant with the newly revised CDs regulations, which came into force in April 2013.²

Last year MPS facilitated more than 150 Clinical Risk Self Assessments (CRSAs) of general practices across the UK.

Due to the complexity of the legislation, an increasing number of practices are choosing not to stock controlled drugs or carry them in the doctor's bag. Notably these were mostly practices whereby a quick response could be received from emergency services.

However, of those practices who held CDs, an analysis of the data from the CRSAs revealed that 13% of practices visited had risks associated with the overall governance surrounding CDs.

These risks included:

- CD registers – no running balance of stock
- Insecure storage – not stored in a lockable cabinet
- Incorrect destruction of CDs
- Carrying CDs in the doctor's bag without concise records.

So what are the rules and regulations surrounding CDs?

Accountable officers

An accountable officer appointed by the NHS Commissioning Board has authority to visit your practice unannounced to review the storage and records of CDs.

The CQC also has responsibility to make sure that health and social care providers maintain a safe environment for the management of controlled drugs. It incorporates CD governance arrangements into its inspection model for primary care.³

Storage

The Misuse of Drugs Regulations (1973) state that all schedule 2 (eg, opiates) and some schedule 3 (eg, temazepam) drugs should be stored in a metal secure cabinet or safe fixed to the floor or wall.

A designated person should be responsible for the CDs and appoint key holders. The keys should be kept in a confidential location no unauthorised members should have access to it.

Controlled drugs register

Any practice storing CDs should have a controlled drugs register (eg, bound book or electronic form). These records must be kept for two years and a separate book must be held for branch surgeries. If the CD register is electronic it should be auditable, printer friendly and display the information details clearly.

In the book a separate sheet must be used for the strength and form of each drug. You must record:

- The date the supply was obtained
- The name and address from whom it was obtained, including the quantity of ampoules.

To ensure accuracy it is best practice to record:

- Running balances of each drug
- The prescribers identification number and/or the professional registration number of the prescriber (where known).

Stock checks

The practice should undertake regular stock checks, ideally by two healthcare professionals. Both should initial the entry if a book is used. Any discrepancies should be investigated and recorded in the CD register correcting the discrepancy in the balance.

Keep a record of the action taken when a discrepancy occurs. If you cannot resolve the discrepancy, inform the accountable officer.

Doctor's bag

All healthcare professionals in legal possession of CDs have a professional duty of care to take all reasonable steps in maintaining safe custody of CDs.

If a GP wishes to carry CDs in his/her bag, the following should take place:

- A staff member should witness the GP stocking the bag from the CD stock and record an entry in the CD register.
- The CDs should be stored in a lockable receptacle, which can only be opened by the person to whom the regulation applies. A digital combination lock is a convenient solution. Bags containing CDs should not be left in a vehicle overnight, or for long periods of time.
- Each doctor must keep a register for the CDs carried in their bags. The GP is responsible for those drugs.
- Administration of a CD to a patient should be recorded in the doctor's CD register.
- If a CD has expired, the GP should return it to the practice stock awaiting destruction. This should be recorded in both registers. If there is no practice stock, then the expired CD needs to be destroyed directly from the bag and witnessed by an authorised person. A record should be made.

Destruction of CDs

Practice staff are not allowed to destroy expired or unwanted CDs from their stock without the destruction being witnessed by an authorised person nominated by the accountable officer. This authorised person should:

- Not be someone who is involved with the day-to-day management and use of the CDs
- Be trained to undertake this role and subjected to a professional code of ethics and/or a DSB check
- Use the CD denaturing kit in destruction.

When a CD has been destroyed, details of the destruction should be recorded in the CD register. This should include:

- The name of the drug
- Form
- Strength and quantity
- The date it was destroyed
- The signature of the authorised person who witnessed the destruction and the authorised professional destroying it (ie, two signatures).

If a patient returns a CD from their home it is best practice that the CD is destroyed in the presence of an authorised person, and a record should be made of this action. Ideally you should ask the patient to return the drugs to the local pharmacy.

Standard operating procedures

Practices should draw up a protocol for the management and handling of CDs. It should include all points discussed in this article and be in accordance with Department of Health guidance.⁴

So how are practices doing?

A recent CQC report states that practices have made significant progress in implementing regulations in response to the Shipman inquiry. General practice teams are now registered with the CQC and will have to provide evidence that they are compliant with all the essential standards of quality and safety.

This includes regulation 13, outcome 9b that relates to the management of CDs. Inspection teams will require practices to provide evidence of compliance; this could include inspection of CDs storage facilities, reviewing the CD register, and asking staff about the practice policy on the overall management of CDs.

Are your controlled drugs procedures up-to-date? Could they be identified as a risk within your practice? Book a **Clinical Risk Self Assessment** with MPS to find out.

For more information visit www.mps.org.uk/crsa or contact our dedicated team on 0113 241 0359, or by email at crsa@mps.org.uk.

Top tips for the management of controlled drugs in general practice:

-  Ensure that CDs are kept in a fixed metal lockable cupboard or safe.
-  Maintain a CD register, including a running balance of stock.
-  Ensure that all entries are recorded on a separate page for each drug.
-  Wherever possible, two healthcare professionals should check all stock, initialing entries in the CD register.
-  Ensure all GPs have individual registers for CDs in their bags.
-  Develop a system for checking the expiry dates of drugs in GPs' bags. Consider creating a log of all drug carried in the bags.
-  Ensure that expired CDs are destroyed by an authorised person.
-  Develop standard operating procedures for the management of CDs.
-  Consider whether or not the practice needs to hold a stock of CDs.

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Prescribing



Dr Mark Dinwoodie, head of member education at MPS, describes how GPs and nurse prescribers can minimise their risk of making prescribing errors

“Hello...did you mean to prescribe...?” I suspect most prescribers will have received this call from a pharmacist at least once, if not several times in their career. Prescribing is a complex process complicated by an ageing population, increasing co-morbidity and growing polypharmacy in the challenging environment that is contemporary general practice.

In light of recent publications relating to the optimal use of medicines, now is an opportune time to reflect on some issues and requirements around prescribing and how we might reduce risks to ourselves and our patients from prescribing and medication errors.

Cyril Chantler, Professor of Paediatric Nephrology, said in 1999 that “Medicine used to be simple, ineffective and relatively safe. It is now complex, effective and potentially dangerous.”¹ While he was referring to healthcare generally, the same can be said of medication.

Context

Prescribing medicines has the potential to alleviate symptoms for patients, as well as to treat and prevent disease or illness. However, it also has the potential to do great harm (as evidenced in Box 1). Harm from medicines may be due to the drug itself or the way they are used by patients or professionals. The interfaces of care are common situations for error and harm to occur, such as the admission and discharge of a patient from hospital.

BOX 1

Harm from medication

- 2.7% to 6.5% of admissions²⁻⁴ caused by adverse drug reactions (2004 data extrapolated to suggest 5,700 deaths and £466m annual cost in the UK; two thirds preventable.^{3,4})
- 3.7% of all admissions due to preventable medication related issues: prescribing (35%), monitoring (26%), and adherence to medication (30%)⁵
- 15% of GP patient safety incidents reported to the NPSA in 2013⁶
- 20% of GP claims for negligence (MPS data)
- Unintentional discrepancies in discharge medication subsequently received from GP: 46-60% items; 57% patients.⁷⁻¹⁰

The medication error iceberg

Medication errors are frequent, however the detection and reporting of them is low. They range from potential errors through unnoticed errors, errors that don't cause harm (near misses) to errors that cause harm.

One of the challenges is that the same error can cause completely different outcomes according to the setting and context, eg, prescribing a contraindicated drug or the right drug to the wrong patient may not cause any harm, or it could result in severe harm or a patient's death (see case below).

Prescribing is a good example of the “Swiss cheese” model proposed by James Reason¹¹, representing a combination of individual active errors and latent system errors resulting in error-producing conditions (the holes). As healthcare professionals we are more likely to make errors if certain error-producing conditions exist.

The slices of Swiss cheese represent steps in the process and possible layers of defence. The more layers of defence, the less likelihood that all the holes will line up and harm will occur. These layers of defence will probably be a mixture of individual, system and technological processes. Fortunately, most medication errors don't cause significant harm, either because the potential for harm is small or one of the defensive barriers (layers of Swiss cheese), such as double-checking by the pharmacist prevents the error from harming the patient.

CASE

Right drug, wrong patient



Mr B died after being confused with another patient at his GP surgery with a very similar name. As a consequence, Mr B was prescribed a non-steroidal anti-inflammatory in error, a drug to which he was highly allergic.

The error was not picked up when he collected his prescription from the surgery or when he collected the incorrect medication from the community pharmacy. Unfortunately he died as a consequence of his allergic reaction.

There are many facets as to how we manage medicines, resulting from interplay between healthcare professionals, patients and their carers, the medicine itself and the systems we use. Recently the term “Medicines Optimisation” has emerged as a way of trying to focus all these influences and processes on producing the most beneficial outcome for the patient where medicines are involved.

This is particularly the case as polypharmacy becomes increasingly prevalent in an ageing population with multi-morbidity and more indications for medicine usage. Polypharmacy can be appropriate or problematic as discussed in a recent review by the King's Fund.¹²

Prescribing errors account for 15% of GP patient safety incidents reported to the NPSA in 2013



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Prescribing errors

The GMC-commissioned PRACtICE study conducted in 2012 gives us our most up-to-date and detailed understanding of the prevalence and nature of prescribing errors in general practice.¹³ Prescribing errors were relatively common with 4.9% of prescriptions containing a prescribing or monitoring error.

One in 500 prescriptions was deemed to contain a serious error. However, with around one billion items being prescribed in general practice in England this year, even a small error rate, if extrapolated, means large numbers of errors with potential episodes of severe harm. (I.e, two million prescriptions with a serious error out of the one billion prescribed annually in England).

Factors contributing to error-producing conditions, as identified in the PRACtICE study could be grouped into seven categories¹³ (see Box 2).

How can we reduce prescribing errors?

What we are trying to achieve is not only a way to minimise the likelihood of making an error in the first place, but also if we do make an error, that there are enough layers of defence to detect the error or minimise the likelihood of harm occurring. Harm reduction due to errors can be summarised as prevention, capture or mitigation.

Suggested interventions to reduce the risk of prescribing errors:

At an individual level:

- Therapeutic knowledge and skills especially around multi-morbidity and polypharmacy
- Standardised approach to prescribing, eg, using the MPS PRESCRIBER© checklist
- Patient involvement
- Following best practice
- Medicines optimisation.

Through technology:

- Ensuring legibility
- Alerts – eg, monitoring reminders; drug-drug and drug-disease interactions
- Processes – eg, electronic prescription service.

At an organisational level:

- A culture that encourages safety and quality in relation to prescribing
- Safe, effective and efficient systems to enable the optimal use of medicines – eg, repeat prescribing system; drug monitoring
- Achieving reliable implementation of systems
- Attention to human factors – eg, minimising distractions and interruptions
- Reduction in error-producing conditions – eg, removing hazards by separate storage of similar looking drugs
- Clinical governance – eg, significant event analysis
- Strategies for higher risk situations – eg, care homes; potentially toxic drugs
- Use of pharmacists and prescribing advisors as a resource.

BOX 2

Categories of error-producing conditions



1. The Prescriber
2. The Patient
3. The Team
4. The Working environment
5. The Task
6. The Computer system
7. The Primary/secondary care interface

Effective communication, particularly around the interfaces of care:

- Early medication review and reconciliation following hospital discharge.

These issues are addressed in more detail in our three-hour workshop, **Medication Errors and Safer Prescribing in Primary Care**. It includes the MPS PRESCRIBER© checklist of key tasks, which contributes to the effectiveness and safety of prescribing and helps to ensure that important steps aren't overlooked, eg, considering whether the patient might be pregnant, checking for drug-disease interactions and arranging monitoring. To book your place and find out more about this workshop, please visit the MPS website.

Earn CPD points by attending an MPS workshop

All participants who complete a Proof of Attendance form at the workshop will receive a certificate detailing the title of the workshop, date of attendance and duration of the event. The **Medication Errors and Safer Prescribing in Primary Care** workshop has been certified as conforming to accepted guidelines and is worth three hours of CPD.

The following MPS workshops also have

CPD accreditation:

The *Mastering* series, covering:

- Adverse Outcomes
- Professional Interactions
- Difficult Interactions with Patients
- Shared Decision Making
- Mastering Your Risk
- Medical Records for GPs.

To find out more about our full range of workshops and to book your place, visit our Education pages on the website: www.medicalprotection.org/workshops.

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Sample AKT questions

With Dr Mahibur Rahman
from Emedica



1. Which of the following is part of the core treatment recommended for treating osteoarthritis in the current NICE guidelines?

- | | |
|----------------------|---------------------|
| A. Steroid injection | D. COX-2 inhibitors |
| B. Topical NSAIDs | E. Exercise |
| C. Oral NSAIDs | |

The correct answer is E: Exercise. The core treatments recommended in the updated guidance (NICE 2014) are exercise to strengthen muscles, aerobic exercise, weight loss for those that are overweight or obese and access to appropriate information. Additional/ adjunct treatments include paracetamol +/- topical NSAIDs. Topical NSAIDs should be considered ahead of oral NSAIDs, COX-2 inhibitors and opioids.

2. Patients with which of the following risk factors should be offered testing for chronic kidney disease (CKD)?

- Obesity
- Afro-Caribbean patients aged over 55
- Family history of chronic kidney disease (CKD)
- Ischaemic heart disease
- Age over 65

The correct answer is D: Ischaemic heart disease. The 2014 guidelines recommend testing for CKD using eGFR/creatinine and albumin-creatinine ratio to people with diabetes, hypertension, acute kidney injury, cardiovascular disease (ischaemic heart disease, chronic heart failure, peripheral vascular disease or cerebral vascular disease) as well as those with structural renal tract disease and those with family history of end stage kidney disease (rather than just CKD). Obesity without other risk factors does not require CKD testing, and testing should not be done solely on the basis of age or ethnicity (NICE 2014).

3. A patient requests access to information from their medical record under the Data Protection Act. They have included the required fee with their written request. What is the maximum time allowed for you to allow access?

- | | |
|---------------------|--------------------|
| A. 40 calendar days | D. 28 working days |
| B. 40 working days | E. 20 working days |
| C. 28 calendar days | |

The correct answer is A: 40 calendar days. The Data Protection Act 1988 (DPA) allows patients to make a subject access request to anyone holding personal data about them. Practices can charge £10 for access/copies of electronic records, or £50 for paper or mixed records. The practice must ensure that any third party information is removed or redacted. Once a valid request and fee is received, access must be granted within 40 calendar days.



Dr Mahibur Rahman is the medical director of Emedica, and works as a portfolio GP in the West Midlands. He is the course director for the Emedica AKT and CSA Preparation courses, and has helped several thousand GP trainees achieve success in their GP training examinations since 2005.

MPS members can get a £20 discount off the Emedica MRCGP courses. Details of the courses are available at www.emedica.co.uk



The Apprentice

In her last column, our columnist *Laura Davison*, talks about her experiences of being a new GP

So, 18 months have passed since I qualified as a GP. It's been a varied time; going from locum to salaried to expedition doctor, back to salaried then acting up as partner for maternity leave cover and back to salaried again. I've joined the Ministry of Justice to sit on their social entitlement appeals panels and I've been keeping the *Practice Matters* editors busy correcting my grammar. This is the marvellously eclectic menagerie of possibility that is a career in general practice. It's also been challenging, tiring and stressful.

Being the new doc on the block is a shock to the system, with the jump from sheltered registrar to self-sufficient, autonomous, fully-qualified GP being a much darker change than I anticipated. It appears I am not alone; my fellow "First Fives" on the whole are having similar experiences. MPS surveyed 246 GPs who had qualified in the last three years. The survey took place in August this year. MPS's new GP survey showed most of us "newbies" are going through the same pressures, feeling overworked, unsupported and overwhelmed by the depth of the task. 78% of us struggled with heavy workload and 59% struggled with long hours.

Our new doctors are also feeling the pressure regarding preparation to deal with modern legalities and defence medicine. My boyfriend freaks out if he thinks he's going to get a complaint for running ten minutes late – imagine the stress if he was faced with a real complaint! Only 25% of us surveyed felt prepared for writing reports and a mere 23% felt equipped to handle a claim.

The burden of an increasingly litigious society is obviously a concern for new doctors and I worry if we are not prepared during our registrar training, the way we practise medicine will head in an ever increasingly defensive direction, changing what is good practice into overly-cautious, potentially unnecessary practice. I've found the MPS Advice app incredibly useful this year, being easily accessible on my phone, hidden in my office drawer, for any quick reference and reassurance.

The RCGP's CSA examination on the consultation and rapport skills needed to be a GP has evidently boosted new GPs' confidence, as a whopping 91% surveyed by MPS felt well prepared with interpersonal and communication skills and 91% felt well prepared for obtaining consent from patients. But I feel that this area should be more of a natural asset of a trainee rather than a taught one, and having such a heavy focus on this area is overlooking gaps in our training covering other essential bases. Triage, business and service procurement, safe repeat prescribing, complaints and conflict handling, staff management and efficient knowledge updates are a few that I've struggled with during my apprenticeship so far.

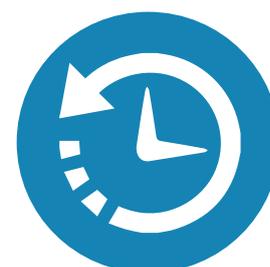
Who knows where general practice is heading, but we are clearly not alone in our worries and struggles as newly-qualified GPs. Being a registrar was just a glimpse of what was to come in the real world.

Although this is my last column under this title, there is so much still to learn and experience; it's going to be a long time before I feel like anything other than an apprentice.

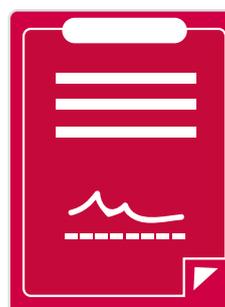
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If you are a GP Registrar, or a new GP with a flair for writing,
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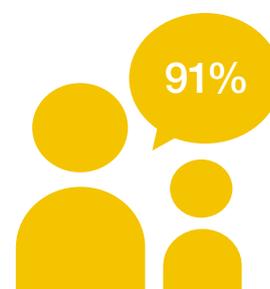
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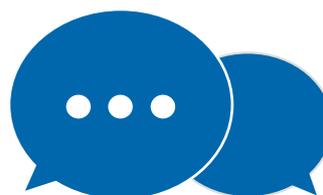
STRUGGLED WITH
LONG HOURS



ONLY 25% FELT
TOTALLY PREPARED/
PREPARED/SLIGHTLY
PREPARED FOR
WRITING REPORTS



FELT WELL PREPARED
WITH INTERPERSONAL
AND COMMUNICATION
SKILLS



91% FELT WELL
PREPARED FOR
OBTAINING CONSENT



ONLY 23%
FELT PREPARED
TO HANDLE A
CLAIM

87% FELT WELL
PREPARED FOR USING
CHAPERONES



In the hot seat with... Professor Nigel Sparrow



From October, the CQC will begin to rate GP surgeries in England as: Outstanding, Good, Requires Improvement

or Inadequate. For a GP surgery to be Outstanding or Good, it will have to demonstrate that it is compassionate, caring, open, transparent, that it learns from its mistakes, seeks to make sure there are no barriers to accessing care for its patient population, and that it has a person-centred approach to care.

A practice will have to show that it makes sure people are able to see a doctor when they need to and that they do not have to wait too long for appointments.

I have been a GP for the last 30 years, and am well aware of the pressures that GPs and their practices are working under – increasing workload, NHS changes, financial constraints, workforce problems, and revalidation, to name a few. It is my role as senior national GP advisor to recognise the problems and develop shared solutions.

What do practices need to do?

Practices need to be proactive in assessing and monitoring the needs of their population, including for people in vulnerable circumstances, such as the elderly, homeless people, traveller communities, and those with mental health needs. You have to demonstrate that you are reaching out to these communities, including making sure that people can register with a GP if they have no fixed abode and that they can access the practice's services without fear of stigma or prejudice.

How does the new inspection methodology work?

The CQC's new methodology covers five domains: are services safe, effective, caring,

well-led and responsive to people's needs?

In general practice we will be looking at six population groups: working age and those recently retired, people with mental health conditions, people with long-term conditions, vulnerable excluded groups, older people and mums, babies and children.

There will be a GP at every visit and each visit will be clinically led and led by specialist inspectors.

How will the new rating system work?

In each of those five domains we're finding out what good practise looks like across the six population groups. As well as fulfilling our regulatory function we also want to celebrate good practise.

Each practice will get a rating over five domains and six population groups and an overall aggregate rating.

Do you think the new system will improve general practice?

The CQC is not an improvement agency, but we are there to encourage improvement. By describing what good practise looks like, practices will be able to see where they need to improve in comparison. I see this as a practice appraisal; they can showcase what they've done well and hopefully where they see their development areas.

What are the next steps?

We are running a pilot over the next few months and will be implementing our new regulations and the new model from the end of October. Every GP surgery in England will have been inspected and rated by April 2016.

We are also visiting CCGs, and will visit 25% of practices during this time. We will be talking to the area team and the CCG prior to visit to get to know about the health community. All of our visits will be calibrated, so practices visited in Cornwall will be the same as visits in Yorkshire. Quality is really important to us too so we'll be quality assuring all of those visits.



What does health and social care look like in England?

Every October, the CQC reports on the state of health and adult social care in England – what hospitals, GP surgeries, care homes and other services are doing well, what is causing concern and any improvements that should be made.

The findings are based on published evidence and what inspectors have witnessed on the 35,000+ inspections that they carry out every year.

Last year, the CQC found that more than half a million people aged 65 and over were admitted to A&E with potentially avoidable conditions, and that people with dementia continue to have poorer outcomes in hospital, which suggests that GPs and social care services could be working together better.

The findings in their latest report help to identify common problems so that services can improve the care they provide for people across the country.

Professor Nigel Sparrow, senior national GP advisor at the CQC, chats to Charlotte Hudson about the regulator's new ratings for GP surgeries



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What's changing

The new changes come in three distinct phases:

1. **October 2014:** The new inspection model comes into force
2. **April 2015:** The Fundamental Standards come into force (subject to Parliamentary approval)
3. **April 2015:** New 'Duty of Candour' makes it a criminal offence if patient is not told true facts of incidents, in a face-to-face meeting
New 'Fit and Proper Person' test will become a statutory duty. It will be an offence not to comply or if you do not remove an unfit person from the management.

Which legislation is changing

OLD	NEW
Health and Social Care Act 2008 - Chapter 14	NO CHANGE
HSC Act 2008 (Regulated activities) Regulations 2010	HSC Act 2008 (Regulated activities) Regulations 2014 <i>Also called "Fundamental Standards"</i>
Care Quality Commission (Registration) Regulations 2009	NO CHANGE
Essential standards of Quality and Safety	Provider Handbook <i>The old 278 page Guideline is now replaced with a provider handbook</i>



The CQC's top changes

1. Better, more systematic use of people's views and experiences, including suggestions and complaints.
2. New expert inspection teams including trained inspectors, clinical input led by GPs and nurses, practice managers and GP Registrars.
3. A rolling programme of inspections carried out systematically in each CCG area across England.
4. Inspections of GP out-of-hours services to be incorporated into CCG area programmes.
5. A focus on how general practice is provided to key patient groups, including vulnerable older people and mothers, babies and children.
6. Tougher action in response to unacceptable care, including where necessary closing down unsafe practices.
7. Ratings of all practices to help drive improvement and support people's choice of surgery.
8. Better use of data and analysis to help us to identify risk and target our efforts.
9. Clear standards and guidance to underpin the five key questions we ask of services: are they safe, effective, caring, responsive and well-led?
10. Close collaborative working with CCGs and Local Area Teams of NHS England to avoid duplication of activity.

Source: CQC, *A fresh start for the regulation and inspection of GP practices and GP out-of-hours services.*



Listen to Professor Sparrow's podcast – www.medicalprotection.org.uk/podcasts/nigel-sparrow-cqc-inspecting-gp-practices

From the case files...

Each issue the team that bring you *Casebook* share interesting general practice cases

In this issue we bring you two interesting cases; the first encourages GPs to exercise caution when diagnosing haematuria, and the second highlights how various poor communication channels can have a negative impact on patient care.



Missed haematuria

Mrs S, a 46-year-old female patient and infrequent attender visited her GP Dr Q with symptoms of increased urinary frequency. Mrs S had had a couple of urinary tract infections in the past, but was otherwise well. She had no other symptoms, but when Dr Q explored the history further, Mrs S explained that she had noticed a little blood in her urine that morning because she had experienced similar problems with UTIs in the past, was not particularly anxious about it.

Dr Q asked Mrs S to produce a urine sample, which on dipstick testing demonstrated the presence of red blood cells (*dipstick haematuria*). Dr Q decided to send the urine sample for laboratory analysis and in the interim prescribed a three-day course of antibiotics for a suspected urinary tract infection.

Later in the week, the laboratory provided an interim urine microscopy result that demonstrated the presence of red blood cells, with the culture results pending. Dr Q was on annual leave so the results were reviewed by a Dr U, who filed the result as *normal*, before departing on a period of leave.

After the weekend, the culture result came back from the laboratory and it demonstrated *no growth*. Another GP colleague Dr S reviewed the result and filed it away as normal without reviewing the previous urine microscopy result.

Several months later, Mrs S represented with frank haematuria and weight loss. Dr Q referred her under the two-week rule for further investigation. Unfortunately, Mrs S was diagnosed with bladder carcinoma.

Mrs S pursued a complaint in relation to an alleged delay in diagnosis of bladder

carcinoma. In the context of the investigation of Mrs S's concerns, a significant event analysis was undertaken with reference to the relevant local NICE guidance (*Urinary tract infection [lower] – women [with visible or non-visible haematuria]*).

As a result of the significant event analysis, all the GPs and the practice nurses were updated in relation to the management of haematuria and a practice protocol was produced.

Advice

This case highlights the difficulties that can arise when several different GPs are involved in the assessment of a patient, together with the analysis of the laboratory results.

In this case, matters were further complicated by the fact that the results were returned from the laboratory in a *piecemeal way*.

Frank or microscopic haematuria with no proven cause is potentially a sign of cancer of the bladder and renal tract and always needs to be taken seriously. This can be really difficult in general practice given the numbers of patients who present with urinary symptoms.

Haematuria can be classified as:

- Symptomatic non-visible haematuria (S-NVH)
- Asymptomatic non-visible haematuria (A-NVH) where there may be incidental detection in absence of symptoms.

The NICE guidance states for all women with visible or non-visible haematuria: "If infection has been confirmed re-test the urine for blood with a dipstick after completing treatment with an appropriate antibiotic, to detect persistent haematuria. Persistence is defined as two out of three dipsticks positive for blood on separate occasions.

Refer urgently for investigations of suspected urological cancer if:

- Infection is not confirmed on culture.
- Visible haematuria persists after infection has been successfully treated.
- Non-visible haematuria persists after infection has been successfully treated in a person more than 50 years of age.
- Visible or non-visible haematuria is associated with persistent or recurrent urinary tract infection in a woman aged 40 years or older."

In the case of Mrs S, referral under the two-week rule was indicated when an infection, but the presence of red blood cells, was not confirmed on urine culture.

NICE are due to publish their guidance, *Diagnosis and management of bladder cancer* in February 2015.

REFERENCES

1. NICE guidance; *Urinary tract infection [lower] – women* – <http://cks.nice.org.uk/urinary-tract-infection-lower-women>
2. NICE guidance (to be published February 2015); *Diagnosis and management of bladder cancer* – link: www.nice.org.uk/guidance/indevelopment/GID-CGWAVE0600

The Swiss cheese

Mrs X gave birth to J, a healthy baby boy. J was discharged, with a note in the records stating he was a “normal healthy infant”; a further note stated that, on examination, there was a bilateral red reflex.

At four weeks, the health visitor’s notes showed that J’s parents were concerned that J’s left eye was smaller than the right, and the health visitor referred the baby to a community paediatrician. A couple of weeks later, the health visitor documented the left eye as being more open and the referral was cancelled.

J was then seen by the family’s GP, Dr A, for a six-week check-up; his vision and hearing were recorded as being “satisfactory”. At three months, Dr A referred J to the ophthalmology department after noticing a squint in his left eye; the left pupil was also smaller than the right pupil. Six weeks later – before the ophthalmology consultation took place – J was admitted to hospital as an emergency via Dr A, with coryza, vomiting and poor feeding. J was transferred to the paediatric department, but there was no record from this admission of any examination of J’s eyes.

At six months, J’s ophthalmology appointment took place. He saw a consultant ophthalmologist, Dr H, who noted that she could not detect any visual acuity in the left eye and that the eye was microphthalmic. She also noted a central cataract on the left side. J eventually became blind in his left eye.

His parents made a claim against Dr A and the hospital for the delay in the diagnosis of the congenital cataract.

Expert opinion

Expert GP opinion on breach of duty stated that Dr A had not been diligent when initially examining J’s eyes at the time of the six-week check. By that time the health visitor had listed initial concerns about the size of the eyes, which should have prompted Dr A to be meticulous in his examination of the eyes; had the red reflex been absent, referral to a specialist should have occurred immediately. Prompt and appropriate referral would have led to a 20% chance of restoring J’s visual acuity to a level adequate for driving.

Another expert report, provided by a consultant ophthalmologist, also stated this examination was inadequate, as an abnormal red reflex would almost certainly have been present; this would have allowed for appropriate surgical intervention of the cataract that was later diagnosed.

This report also criticised the hospital paediatric department for failing to communicate the concerns in J’s records about his eye size to the appropriate colleagues. The case was settled for a substantial sum.



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Learning points

- Poor communication leads to poor treatment. Here there is poor communication at various stages, between GP and hospital and within the hospital itself.
- Congenital cataract has a finite time period in which surgical intervention is beneficial.
- J was not seen by a consultant ophthalmologist until he was six months old; this delay highlights failings at both ends. Dr A’s referral letter did not make the urgency of the appointment clear but, also, the recognised association of microphthalmia with congenital cataract should have prompted the consultant reading the letter to offer an urgent outpatient appointment.

This case appeared in the May 2014 edition of Casebook. Access more cases at www.medicalprotection.org/uk/education-publications/casereports



The canary in the coalmine

Dr Paul Heslin, a GP and occasional locum based in Dublin, looks at the misunderstood life of a GP locum

Being a GP locum has long been misunderstood and undervalued. The specialty of GP locum is the Cinderella of medicine.

Once thought of as the poor ragged cousin of the medical family, locum work was seen as being suitable for doctors at the beginning and end of their careers. No proper doctor should see it as a real career path. It was ok for the young, inexperienced doctor before he got a real job for life; it was also ok for retired doctors after a life of experience, a sort of reward after a life of service, being put out to pasture.

A "real" GP was totally committed to their 24/7/365 "calling", with a personal continuity of care to "his" patients being a badge of honour. General practice made way for group practice, patients seeing different doctors, and sessional practice.

The specialty of GP locums have being doing this for years: treating complex patients in brief, discontinuous interventions; sometimes picking up things the GP has missed; bringing a fresh perspective; fitting in and adapting to each practice. The emergent and modern, high-quality locum often brings new ideas from their travels among the many tribes and subcultures of general practice within Ireland and overseas. And it is this wider experience from medical travel that makes locums an underused resource to practices that want to use their diverse font of knowledge.

It is also one of the risks of being a locum. You see that things can be done differently in other places, and sometimes better, but the practice you are working in today might not fully appreciate the gift that you are offering them and may well bite back. No-one likes change, but for the lowly locum to come into a practice, and announce that they have seen things done better, or differently elsewhere, it can be taken as an insult.

It was a simple thing, a small thing, when I offered a Carlow practice (before computers became the rage), the idea that it might be better to write the constantly changing addresses of their patients in pencil rather than pen on the front page of their paper records so that five addresses were not overwritten in mad,

unreadable scribbles.

This Carlow GP practice took the new idea to heart and found great benefit from it. Other practices can be more wary of new ideas from the new kid on the block. Specialist locums feel the added vulnerability of being a short-term locum. Like walking into a well-designed kitchen, where you just "know" where everything is, some well-organised practices "flow" and are easy to adapt to.

Other practices are hard work – and have added risks for the transient doctor. Locums experience both the safe and unsafe practices in various GP practices.

They have not yet become accustomed to the idiosyncrasies that each practice develops over time and which each practice comes to think of as normal.

Locums have to deal with the fact that many practices do not recognise the particular risks for locums as well as the unique expertise that they bring. These local solutions can become real challenges for locums, or real bonuses and new ideas to be spread by bumble bee locums to other receptive and flowering GP practices. In this way, specialist locums can become the mediators of good practice and alternative practice, spreading the good news like travelling storytellers of Irish folklore. They can be the cross-fertilisation seeds of new possibilities to other GPs who do not have the same privilege of medical travel and diversity.

Small things matter when you are a locum, like the much used computer keyboard with the letter "C" worn away and unreadable. The locum finds himself asking: "What is the letter to the right of "X"? It is "C". (By the way, the most used letter in the alphabet is "E".) The



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permanent GP is happy to work with the worn keyboard and has adapted over time, but the locum is completely put off by this added risk. And this can sometimes be just one of the cumulative risks that a locum has to adapt to, in swift time. This is the unique skill and talent of the professional locum.

If a GP needs to know a little about every specialty of medical practice, then a GP locum needs to know this as well as something about every type of general practice, with different computer software, different habits and different risks. But most of all, locums have to deal with the fact that many practices do not recognise the particular risks for locums as well as the unique expertise that they bring. Like the canary in the coalmines, the locum can be an early warning sign of risk in your practice.

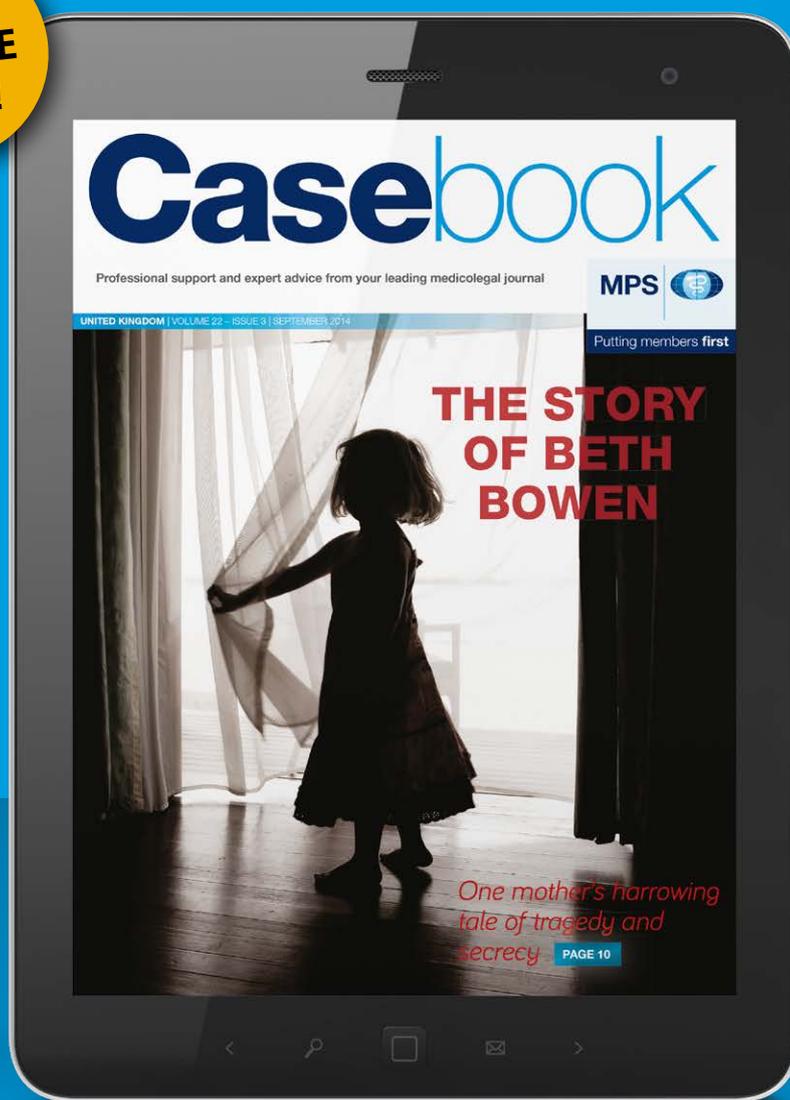
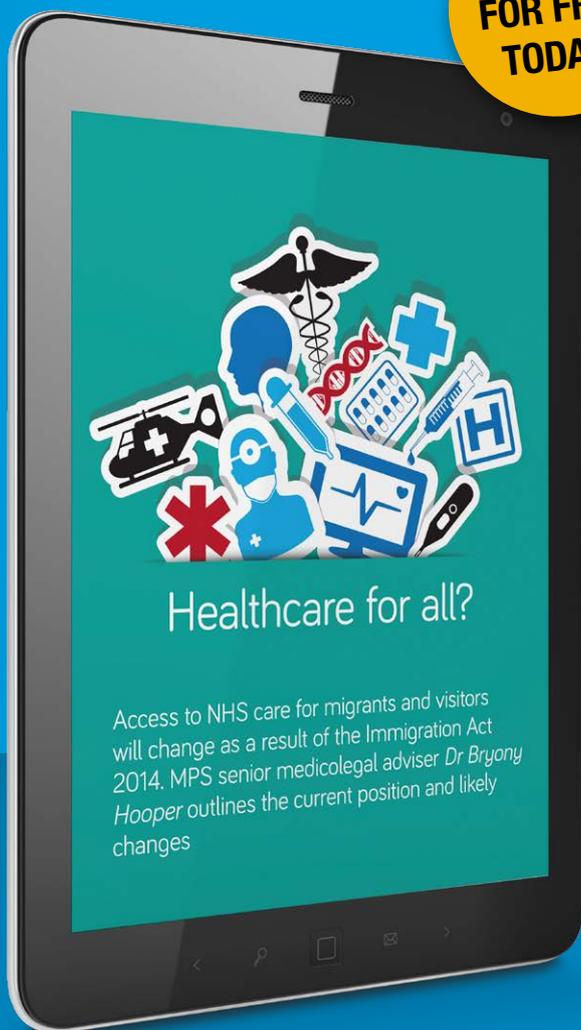
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