Practice Manager
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KEEPING THE FAITH
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PRESCRIBING

KEEPING YOUR PRACTICE SYSTEMS SAFE

PRACTICE PROFILE
BLUE SKY DENTAL

MDDUS

Practice Manager

A KEY risk area for any practice manager is the management of repeat prescribing systems, as even a minor oversight can have major consequences for patient safety. A recent GMC study found one error in every 20 prescription items within general medical practice – a sobering statistic. All practices will have their own unique systems for dealing with repeat prescriptions but there are patterns in the types of systems failures that contribute to patient harm and these can highlight often avoidable risk. On page 12, MDDUS training and consultancy manager Liz Price offers advice to managers on how to create a system to minimise mistakes.

Keeping with the theme of prescribing, our case study on page 14 looks at the case of a GP whose choice of medication for a diabetic is questioned when the patient develops complications.

The topic of faith in general practice can be a contentious one and on page 8 associate editor Joanne Curran looks at the impact on managers when doctors practise in line with their religious beliefs. What can you do if you discover a patient has secretly taped their consultation. On page 7 MDDUS editor Jim Killgore looks at what your rights are when it comes to covert patient recordings.

The issue of defining workers' employment status is discussed on page 5 where MDDUS employment law adviser Liz Symon explains how to tell if someone is self-employed or if they can be classed as a "worker". Meanwhile our health and safety article on page 6 looks at how practices can ensure their premises are safe for staff and patients.

In the practice profile on page 10 we visit Blue Sky Dental in Bathgate, winner of Best New Practice at the 2011 Dentistry Scotland Awards.

And in our call log on page 4 we tackle topics including moving large numbers of patient files, PRS music licences , the tagging of medical records and the need for translating records.

Aileen Wilson
Editor

Caution urged over patient texts and emails

PRACTICES are being urged to ensure patient emails and text messages don't breach confidentiality.

During flu season many practices may choose to alert specific patient groups via a group email, but MDDUS is advising managers to consider data security.

One recent case involved a practice nurse who composed an email but added the distribution list in the To... field rather than the Bcc... (blind carbon copy) field. This meant each recipient of the alert could view all the email addresses and possibly identify everyone on the list.

This may seem a minor error but it is a breach of confidentiality for every patient on the list – as being on such a list or even a patient at a particular practice is confidential information. Revealing these details breaches the Data Protection Act and goes against guidance from regulators such as the GMC and GDC. The practice was advised to inform the Information Commissioner's Office and apologise to each patient.

MDDUS advises practices who email or text patients to secure their express consent to do so and to agree on levels of disclosure, i.e. should emails or texts be used solely for vaccinations/call backs or for more personal matters such as test results?

Practices must comply with the Data Protection Act and consider encrypting emails where possible. Double-check you have the correct recipient(s), use the Bcc... field for mailing lists and check the recipient's electronic security arrangements are sufficient.

If in doubt, contact MDDUS for advice on **0845 270 2034**.

GDC consults on direct access to dental team

THE GDC is calling for views on a proposal to allow "direct access" to any member of the dental team without referral from a dentist.

Currently clinical dental technicians are the only DCPs able to see patients without need for a referral or prescription (in order to provide complete dentures). The new proposal would extend this to all members of the dental team including dental hygienists and therapists. Earlier this year the Office of Fair Trading called for these changes to be made as a priority and the Department of Health has welcomed the move.

At the same time the GDC is looking for views on new draft standards on conduct, performance and ethics for all registered dental professionals.

These include making it clear to patients which treatments can be provided under the health service and those which can only be provided on a private basis, and ensuring that a simple list of costs is clearly visible in a reception or waiting area.

The standards also call for dental professionals to be sufficiently fluent in written and spoken English in order to communicate effectively with patients, their relatives, the dental team and other UK healthcare professionals.

A third consultation document on mandatory dental CPD has also been launched. Find out more at **www.tinyurl.com/9wxmqj9**

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Dental patients should query indemnity

DENTAL patients are being encouraged to ask their dentist if they have indemnity or insurance cover in a new factsheet produced by the General Dental Council.

The regulator is urging patients to "know their rights" when it comes to pursuing a complaint and getting their money back "if something goes wrong". It explains how indemnity or insurance cover is a way for dental professionals to ensure patients can claim compensation in such cases.

The factsheet states: "Our advice to patients is that you ask your dentist or dental care professional if they are properly insured, or indemnified for the treatment they are carrying out. Our research shows that the vast majority will have measures in place."

It goes on to advise patients how to make a complaint and to contact the GDC "if you think the dental professional treating you is a risk to other patients".

MDDUS head of dental division Aubrey Craig has welcomed patients being given more information about what to expect from their dentist and believes it is further evidence that dentists should be suitably protected and prepared.

He said: "Dentists should ensure they are fully compliant so they can meet their patients' expectations and needs as well as looking after themselves. All dentists should have access to indemnity through their dental defence organisation so they are protected in the event of a claim of clinical negligence."

He also reminded practices to ensure they have an easy-to-follow and clearly visible complaints procedure.

Complaints against doctors at record high

COMPLAINTS about doctors have hit a record high, according to a new report from the General Medical Council.

The number of complaints increased by 23 per cent in a year, rising from 7,153 in 2010 to 8,781 in 2011. It continues a trend that has been rising since 2007.

Despite the figures, the GMC said this does not mean medical standards are falling.

The second annual *State of Medical Education and Practice in the UK* (SoMEP) report showed a significant rise in concerns about how doctors interacted with their patients. Allegations about communication went up 69 per cent while complaints about a lack of respect went up 45 per cent.

The report found GPs, psychiatrists and surgeons attracted the highest rates of complaints. Some 47 per cent of all complaints made were against GPs, who represented 24 per cent of those on the medical register.

GMC chief executive Niall Dickson said: "While we do need to develop a better understanding of why complaints to us are rising, we do not believe it reflects falling standards of medical practice."

He said a range of measures – including the launch of revalidation – were being introduced by the GMC in a bid to enhance patient safety and improve the quality of medical care.

Read *The State of Medical Education and Practice in the UK* at: **www.tinyurl.com/boc9tnp**

Employment Law

MDDUS publishes a twice-yearly online Employment Law Update that brings you up-to-date news and features covering the latest employment law hot topics.

Subscribe now by emailing **PM@mddus.com**

Rule change on holiday sickness

A RECENT ruling by the European Court of Justice now means that employees who fall sick during a period of annual leave are entitled to take that leave at a later date.

The ruling was made in the case of ANGED v FASGA and is the latest in a number of developments regarding employee rights surrounding holiday and sick leave.

This has become a complex area but further guidance from the government is expected shortly.

Other recent court rulings mean workers on sick leave now have the right to accrue leave and can also take and be paid for any accrued annual leave. Similarly, those on long-term sick have the right to take annual leave at a later date and should be paid for this outstanding leave if their employment is terminated.

Employment law templates

THE Employment Law team at MDDUS have a range of useful documentation available, including a template contract of employment, template handbook including social media policy, and factsheets addressing such topics as disciplinary matters, short-term absence, changing contracts and redundancy.

If you are interested in receiving any of these documents, please email **employmentlaw@mddus.com**

Call log

These cases are based on actual advice calls made to MDDUS advisers and are published here to highlight common challenges within practice management. Details have been changed to maintain confidentiality.

REDACTED REPORT

Q A practice has received a request from a local company for a medical report relating to a patient, Mrs B, who is one of their employees. Mrs B has consented to the report but has asked the practice not to mention her previous mental health problems. The practice manager is unsure how to proceed and calls MDDUS for advice.

A When dealing with requests for medical reports, it is the responsibility of the applicant to provide the practice with a written copy of the patient's consent. Before providing a report, the practice must check the patient is aware of what information will be disclosed and that they understand their rights under the Access to Medical Reports Act. By law, if the information is relevant then it must not be excluded. In this case, Mrs B's GP should discuss the issue with her. If she still refuses to allow references to her mental health treatment, the GP should explain to the company that a report cannot be written, taking care not to disclose the information Mrs B did not want revealed.

MOVING FILES

Q A partner in a dental practice is setting up his own surgery and wishes to take his patients' notes with him. Unfortunately the entire practice's notes are held electronically and cannot be separated. The practice manager asks an MDDUS adviser if the partner can be given a copy of the entire practice's records on a disc so he can access his own patients' notes.

A Giving the partner a disc containing all the practice's records without seeking every individual's express consent would be a breach of the Data Protection Act. Ideally, the information would be electronically separated, with a disc containing the records of the departing practitioner's patients being transferred to the new practice. However, this has often presented technical problems, in which case the best solution would be to download and print the records of the patients who intend to move. While this would undoubtedly be expensive and time consuming, it would ensure that only hard copies of the correct notes are scanned in at the new practice. Before doing so, remember to seek the written consent of the patients who wish to move practice.

PRACTICE PENSIONS

Q A manager has been asked by one of the practice employees whether she will be included in the practice's pension scheme now that the new pension enrolment law has come into force. The manager tells MDDUS the practice has 15 employees and he is unsure if the new law applies.

A The automatic enrolment scheme will apply to all employers, including practices. Practices will be obliged to enrol staff into a pension scheme where they are not already in a pension at work, aged 22 or over, are under state pension age, earn more than £8,105 a year and work in the UK. However, the scheme is being introduced in stages depending on the PAYE scheme size. For practices with less than 30 workers in a PAYE scheme, the earliest they will have to comply is June 2015. It is advised to confirm your auto-enrolment date at: www.bit.ly/QHTfej

MUSICAL MONEY

Q A dental surgery uses radios and MP3 players to play music in its treatment rooms and waiting room. The practice manager has read reports that a recent court decision exempts dental surgeries from having to buy a licence to play music. He calls MDDUS to check.

A The ruling in March 2012 by the European Court of Justice was made in relation to Italian law and does not affect the situation in the UK. Practices DO still need to pay for a licence from the Performing Rights Society in order to play music in their premises, whether via radio, TV, CD, MP3 or live performance. By not having or cancelling an existing PRS for Music licence you may be liable for infringement of copyright. Licences for dental practices start from as little as £44 a year and it would be advisable to purchase one, rather than risk breaching copyright laws.

TAGGING RECORDS

Q A medical practice is reviewing the way it stores information regarding patients with firearm or shotgun licences. After concerns were raised by some of the doctors, a practice manager is considering tagging the medical records of such patients. She calls MDDUS for advice.

A The BMA issued ethical guidance on firearms in July 2011 which advises against placing electronic tags in medical records to indicate whether a patient holds a firearm or shotgun certificate or has applied for one. An MDDUS adviser confirms this is also the Union's position and explains that holding such data would breach the Data Protection Act. Practices are not expected to police the firearms licensing system in this way and would only be required to raise any concerns if notified about a licence application or renewal.

PATIENT TRANSLATION

Q A practice has recently registered a patient from Poland who has been treated for various health issues for the past four months. During his last visit he asked the practice to arrange for his lengthy previous medical records to be translated from Polish to English to allow him to access state benefits. The cost of the job would be around £3,500.

A There is no requirement for the practice to arrange and pay for the translation of this patient's entire Polish records. It would be reasonable to arrange for specific items within the record to be translated if these were directly relevant and necessary to provide safe patient care. It may be useful to discuss contractual issues in more detail with your Health Board/PCT or LMC.

Employee, worker or other?

To be self-employed or not to be self-employed... that is the question!

THE issue of a person's employment status is becoming a bit of a hot topic in employment tribunals at present.

It has long been the case that practices take on locums or associates on a self-employed basis. Being self-employed means that there is no on-going obligation for an employer to offer work, or for an individual to undertake work for that employer. Being genuinely self-employed should mean – in theory – that the person does not even have to undertake the work themselves and can send someone else to do this in their place. How it works in reality in a practice is another matter.

The employment status of an individual is important because certain legal rights only apply to employees, although 'workers' do have some limited rights too. Self-employed individuals generally have no employment rights; however they are covered by anti-discrimination laws, by health and safety legislation and by the law that protects wages. This area of employment law is not the easiest to deal with and increasing case law is now concerned with allegedly self-employed individuals.

The most common employment status you will find in a practice will be an employee – who is defined as an individual who has a contract of service. This means that the practice agrees to provide work and the individual agrees to supply their labour personally. This is known as 'mutuality of obligation' and the individual works under the practice's direction and rules – so there is 'control' in place. Employees with a contract of service have the highest protection in employment law. Only they have the right to claim unfair dismissal or a redundancy payment.

A 'worker' has some rights under employment law, including the right to claim under the Working Time Regulations and to make discrimination claims. They cannot make claims of unfair dismissal or a claim for a redundancy payment. The key requirements for establishing 'worker' status is that the individual has to perform work or services personally and cannot send a substitute or sub-contract the work, and are not undertaking the work as part of their own business.

In contrast, self-employed individuals are engaged under a contract for services and there is no obligation for them to undertake the work and no obligation to be offered work. Self-employed individuals cannot make any claims through employment tribunals and their protection is based on normal contractual principles. Their remedy for breach of contract would be to sue through the civil courts.

A recent case that is of particular relevance to practices involved a hospital consultant who carried out business on his own account but was found by the Court of Appeal to be a worker, rather than self-employed.

Dr Westwood was engaged by the Hospital Medical Group Ltd (HMG) to carry out hair restoration surgery on a self-employed basis. When HMG terminated the agreement, he claimed unlawful deductions from wages and holiday pay. The employment tribunal found that he was a 'worker' under section 230(3)(b) of the Employment Rights Act 1996, as he had a contract to perform services personally for HMG, which was not his 'client or customer'. The Employment Appeal Tribunal (EAT) upheld the decision.

An appeal was eventually heard at the Court of Appeal and the judges identified a need to distinguish between individuals who market their services as an independent person to the world in general (who will have clients or customers), and those who are recruited by the 'employer' to work as an integral part of the employer's operations. Applying this test to Westwood, he fell into the second category. HMG could not be regarded as the doctor's 'client or customer' because it had specifically recruited him to carry out surgical procedures on its behalf and referred to him in its marketing materials as 'one of our surgeons'. He was clearly an integral part of HMG's undertaking and was providing services even though he was in business on his own account and did have other clients or customers of his own.

However, in the case of *Knight v Fairway & Kenwood Car Service*, more emphasis was placed on the wording of the contract, rather than the actual working relationship. Mr K was a mini cab driver and entered into a written contract with Fairway. The contract expressly stated that K was not an employee and was responsible for paying his own tax and national insurance. It was also made clear that K could work when he liked but there was no obligation for him to do so. K worked seven days a week and generally for several hours per day.

K became involved in a dispute with Fairway and left, claiming wrongful dismissal. The tribunal needed to decide his status in order to rule whether it could hear his claim. Both the tribunal and the Court of Appeal held that K was not an employee – due to insufficient mutuality of obligation. It was found that K worked seven days for financial reasons and not because there was an obligation for him to do so.

Determining the employment status of individuals is clearly a bit of a minefield and, without a set formula to call upon, can cause headaches for a medical or dental practice. So if you have any concerns about the status of an individual in your practice it would be wise to seek legal advice. MDDUS members can contact us on 0845 270 2034. ❋

Liz Symon is an employment law adviser at MDDUS

MDDUS offers free in-house employment law and HR advice to practice managers within MDDUS group schemes or members with employment responsibilities.

Call: 0845 270 2034
email: employmentlaw@mddus.com
web: www.mddus.com

Safety by design

IT almost goes without saying that medical and dental surgeries are places where people with a wide variety of health problems are found. But it is important to remember that regular attendees can also include staff suffering chronic health problems stemming from or exacerbated during their time spent on practice premises.

In addition to the practitioners themselves – who are statistically at greater risk than the general population from stress, mental illness and drug/alcohol abuse – clinical and administrative support staff face a range of hazards linked to their work and the equipment they use every day.

Nearly all the physical health risks facing staff stem from a combination of the design of the practice premises and workstations, and the regular work routines that staff follow.

One of the biggest causes of workplace injuries is building design and layout. Slips, trips and falls account for a large percentage of all visits to A&E. Nearly all public buildings now have ramps enabling wheelchair access but in wintry or wet weather these ramps can swiftly become dangerously slippery slopes that are highly hazardous for pedestrians.

In all but the severest weather, ramps can be made safe by regularly spreading grit and/or salt on them. That requires advance planning and someone should be made responsible for ensuring there are adequate supplies of grit/salt.

Inside the building, it's important to ensure that floor surfaces are level and that internal steps are clearly visible and well lit. If necessary, handrails should be installed alongside stairs.

Floors should be surfaced with material that will give ordinary shoes a secure grip. Highly polished wood may look good but it is an invitation to slip and fall. Any carpeting should be fixed to the floor and, when it begins to wear out, should be replaced to prevent trips.

Next for consideration is workstation design. Some work will normally be carried out by employees while they are standing and it's important to ensure that work surfaces are at a comfortable height. It's normally perfectly safe to have to reach up to a shelf to occasionally lift small items during the day, but if a staff member has to use shelving frequently and repeatedly, it should be at an easily accessible height.

Further issues have to be considered in respect of seated workstations. Computer screens, mice, keyboards and printers have transformed the way we work and this technology has brought fresh risks to workers' physical health. Principal among these is RSI, or repetitive strain injury. RSI includes a wide range of musculoskeletal disorders, usually involving the hands, wrists and arms. From a medical perspective the conditions, and the best ways of treating them, vary widely but many can be avoided altogether if thought is put into workstation design.

> "MANY PHYSICAL HEALTH RISKS FACING STAFF RELATE TO THE DESIGN OF THE PRACTICE PREMISES AND WORKSTATIONS"

This involves ensuring that chair height can be adjusted to allow staff using keyboards to reach the keys comfortably, with their arms approximately level with the desk surface. Seats should also have firm backs so staff can sit upright comfortably, thus avoiding slumping and associated postural problems. Back problems are one of the largest single causes of sickness absence.

Prolonged use of the keyboard and mouse can place undue strain on the wrists. In certain cases an alternative keyboard or mouse may provide the solution rather than by using wrist supports, although each situation must be carefully assessed on a case-by-case basis.

A further consideration is screen positioning. Ideally, screen heights and distance from the eyes should be adjustable. This can be achieved with a relatively inexpensive arm fixed to the wall or back of the desk. Staff should adjust the screens to ensure their eyes are at an appropriate distance and that their angle of vision encourages them to hold their heads upright, thus avoiding strain from continually peering up or down.

The appropriate distance will vary depending on the worker's eyesight. Staff whose work is largely screen-based should have their eyes tested regularly at the practice's expense. An alternative for practices north of the border is to ensure staff have regular private eye tests which are free in Scotland.

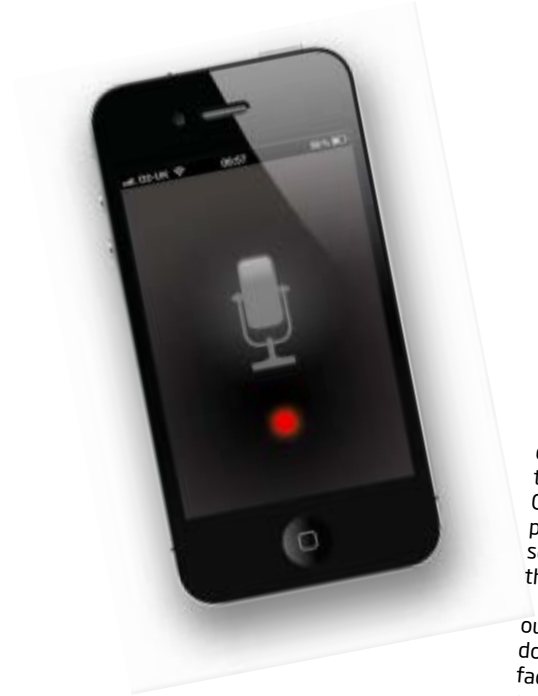
Where a worker's eyesight is deteriorating, and the damage is being caused by screen work, practices should make arrangements to supply spectacles that are specifically designed to make screen use safer and more comfortable.

A final consideration is telephony. Most of us use traditional handsets at home, and the same is true in many workplaces. But if a member of staff regularly uses the phone and computer simultaneously, for instance to book appointments or prepare prescriptions, a headset should be provided instead of a handheld phone. These are relatively inexpensive and eliminate any need for a worker to hold a phone in the crook of their neck while using the keyboard and mouse.

Practice premises are not inherently dangerous, but they are not risk-free. A systematic approach to hazard identification and mitigation will go a long way to ensuring that practice staff are not permanently impaired while working in the health sector. ✱

Gary Foggo is Health & Safety Services Manager at Law At Work

Covert patient recording



A patient uses a smartphone to record a consultation. Is this legal?

LAST February a Shropshire GP appeared before a GMC fitness to practise panel charged with – among other things – carrying on a sexual relationship with a vulnerable patient. Nothing about the hearing was particularly unusual as such cases go apart from the fact that the most damning evidence to emerge came from two covert audio recordings made on the patient's mobile phone.

In the hour-long audio clip which was played out at the hearing the patient is heard to ask during a consultation at the GP surgery "Well. Have you missed me?" to which the doctor replies "Ah come here" followed by the sound of kissing and heavy breathing. Considering all the evidence in the case the panel found the doctor's fitness to practise seriously impaired and he was erased from the Medical Register.

Not to take anything away from the serious misconduct exposed in the case but it does illustrate the risk practice staff now face as technology makes it increasingly easy for patients to secretly record consultations. Most mobile phones and smartphones have record functions which can be easily activated without a doctor or nurse realising. Even hand-held games consoles can record conversations, as one GP recently discovered when a child managed to capture a consultation with his mother – not just audio but video. The footage was deleted immediately on discovery.

LEGAL OR NOT?

The General Medical Council is very clear on the responsibilities of doctors wishing to record patient consultations for any reason. Its detailed guidance on making and using visual and audio recordings states: "You must get the patient's consent to make a recording that forms part of the investigation or treatment of a condition, or contributes to the patient's care, except in the circumstances described in paragraph 10 [where implied consent applies]. You should explain to the patients why a recording would assist their care, what form the recording will take, and that it will be stored securely."

The same however is not true when a patient wishes to make a recording of a consultation. Says MDDUS dental adviser Rachael Bell:

"You might think that a patient would require your permission to record a consultation and that any recording made covertly was illegal. But this is not the case. When a patient seeks a consultation, the information being processed is almost exclusively relating to the patient. Under the Data Protection Act, that data is therefore personal to the patient. By recording it, that patient is merely viewed as processing their own data."

This means the data is confidential to the patient but not to the doctor and there is no law against the patient doing with it as they please – including disclosing it to a third party or even posting it on the internet. Subject to forensic checks by IT experts to ensure no fakery is involved, such recordings could be used as evidence in both regulatory hearings and civil lawsuits. Such was the case in the GMC hearing of the errant Shropshire GP and also recently in another case in the USA in which a group of siblings secretly recorded a meeting with a doctor who apologised and admitted fault on the part of his hospital in the death of their father by cardiac arrest.

"In essence, the patient can do what they wish with it," says Bell. "Even if obtained covertly, courts may view the recording, if relevant to the case, as admissible. Any covert recording would seem inherently intrusive and a breach of trust in a patient-dentist relationship. You would expect sympathy for a doctor or dentist whose privacy had been invaded. However, the law views the matter differently."

WHAT CAN YOU DO?

Much as you might like to ban mobile devices at the door this is hardly a practical or legal solution. Covert recording is not something that can be easily policed and even if a patient is confronted with their finger on the record button it would be inadvisable to refuse treatment on that basis.

Perhaps the most practical advice is to accept the prospect of covert recording as a product of the digital age and ensure that it does not work against you. All practice staff should at all times act with courtesy and professionalism. A recording made in proper context is in one sense no more than a very accurate record of that professionalism. Supplemented with clear and complete patient notes a digital recording should not be anything to fear – much as it may not be exactly conducive to mutual trust. ❋

Jim Killgore is publications editor at MDDUS

Keeping

Some doctors and medical practices choose to care for patients in line with their religious beliefs – so how does this impact on the role of the practice manager?

THE topic of religious beliefs and medical practice has been hotly debated in recent months, thanks largely to a high-profile General Medical Council case that made many media headlines.

It is likely you will have read reports about the Christian GP who was issued a warning by the GMC for causing a patient distress by discussing religion with him. It sparked a furious debate, with the regulator concluding that the GP had breached its guidelines that forbid doctors from imposing their own beliefs onto patients.

While this case might suggest religion has no place in the consulting room, the fact is that many practices across the UK operate quite successfully within a religious or spiritual ethos – whether it be Christian, Muslim, Jewish or another faith. In some instances the practice as a whole operates within a religious framework or often one or more GPs within a practice treat patients in line with their personal beliefs.

What this means in practice is that religious doctors may occasionally choose not to provide certain treatments such as contraception, abortion or sometimes fertility treatment, choosing instead to refer to another physician. Religious doctors may also, where appropriate, broach the subject of faith with a patient during a consultation and in some cases offer to pray with them.

So how does this impact on the role of practice manager?

MAKE IT OFFICIAL

In the good management of any practice it is important to have appropriate policies in place to deal with the many issues that arise and the same applies for faith-related matters.

Where one or more of your GPs practise in line with their faith, and may therefore occasionally choose not to provide certain treatments, it is important to have an appropriate policy in place for dealing with such a situation. This policy should include measures to ensure patient treatment is not adversely affected, it should be in line with the GMC's guidance *Personal Beliefs and Medical Practice* and all staff should be familiar with it.

An updated version of the guidance is currently out for consultation and states that doctors should be free to practise medicine in accordance with their beliefs, provided that in doing so they are not denying patients access to appropriate medical treatment or services, or causing distress to patients.

It also makes it clear that doctors must not express their personal beliefs to patients "in ways that exploit their vulnerability or that are likely to cause them distress." It takes a firmer line on faith discussions, stating: "You may talk about your own personal beliefs only if a patient asks you directly about them or the patient indicates they would welcome such a discussion."

SENSITIVITY

Dr Peter Saunders is chief executive of the Christian Medical Fellowship, an organisation that supports 4,000 practising Christian doctors across the UK, around half of whom are GPs.

He says faith discussions should be based around the principles of "sensitivity, permission and respect". "We would certainly not encourage a doctor to continue a faith discussion if the patient has said they are not interested," he says. "It would only take place if the patient welcomed it."

The GMC's guidance goes on to state that doctors "must explain to patients if you have a conscientious objection... You must tell them of their right to see another doctor and make sure they have enough information to exercise that right." In

the faith

some faith practices, the manager can play an important role in ensuring patients seeking certain treatments are seen by a doctor who will not object to providing those treatments.

Retired GP Dr Kenneth Collins is a former chair of the Scottish Council of Jewish Communities. He says managers in faith practices have a variety of issues to consider.

He says: "In a practice which is solely guided by faith, the practice manager would clearly have an important role in policy issues. There may also be a need to operate a different timetable; for example a religious Jewish practice which will have been closed from before the onset of the Sabbath on a Friday afternoon in December might be expected to have consulting on a Sunday morning."

> "WHERE THERE IS A VARIETY OF FAITHS WITHIN A PRACTICE THE PRACTICE MANAGER WILL HAVE TO ENSURE THAT THE SENSITIVITIES OF EACH GROUP ARE CATERED FOR"

Faith practices sometimes choose to offer a chaplaincy service and the way this is administered should also be set out in a practice policy. Some practices will include information about the service on their website or in practice literature while reception staff may offer patients the option of meeting with the chaplain when they contact the surgery.

It is possible chaplains may request full access to the records of patients they meet and clearly this must be done with the patients' express consent, with the relevant measures in place to protect confidentiality.

INCLUSION

In any faith-related practice it is important that non-religious patients and staff do not feel excluded in any way. This is another important duty for the practice manager.

Dr Collins says non-religious patients must be assured that their care will be of an equally high standard to other patients and that due care will be given to their own value systems, adding: "Where there is a variety of faiths within a practice the practice manager will have to ensure that the sensitivities of each group are catered for."

Where a chaplaincy service is provided, it should be clear that it is available to everyone, regardless of their beliefs. Chaplains will typically be given a room within the practice where they can talk to patients in confidence and offer support in the form of prayer or provide information on church or community support groups.

Similarly, non-religious staff working in faith practices should not be treated differently to their religious colleagues. To show favouritism towards or bias against any member of staff risks falling foul of the Equality Act or other employment laws. And where your practice consists of a mix of religious and non-religious doctors, you should be alert to any potential religious discrimination between colleagues as this is expressly prohibited under the GMC guidance.

If in doubt on any issues regarding personal beliefs and medical practice, contact MDDUS for more specific advice. ❋

Joanne Curran is an associate editor at MDDUS

Blue sky thinking

PHOTOGRAPHY: D MACLEOD

Jim Killgore visits a dental practice that did more than just move premises – it reinvented itself

IT was hardly the ideal location for a modern dental practice – two first-floor flats knocked together in a Victorian tenement and accessed by stairs off a narrow close. But in 1983 dentist Don Macleod and his partner saw it as a good start and George Street Dental opened for business in the town of Bathgate near Edinburgh.

Over the years as the practice expanded with Dr Macleod taking over sole ownership, the space grew increasingly unsuitable for purpose. Among limitations was the inability to create a full-size local decontamination unit (LDU) as well as the lack of disabled access.

"One hundred and ten year old plumbing and modern dentistry do not sit easily together," says Dr Macleod.

"We used to regularly flood the shop below and of course we would be regularly flooded by the flats above."

So it grew increasingly obvious that a new location was called for. But Don Macleod and his practice team saw this as more than just a necessity. Moving practice presented a unique opportunity for change – not just in physical location but in the way the practice operated. And this is how Blue Sky Dental first took shape – and the ultimate result earned Dr Macleod and his team the accolade of Best New Practice at the 2011 Dentistry Scotland Awards.

BLANK CANVAS

I recently visited Blue Sky Dental to ask about the challenges of establishing a new practice. To get an idea of where I was going I typed the Bathgate postcode into Google maps and on checking Street View was shown a modern detached building occupied by an Ethel Austin clothing store. Checking the postcode again I then realised the image predated the move and perhaps my confusion was understandable, as a former retail unit may not seem an obvious location for a new dental practice.

"It was like a blank canvas," says Kerry Lambie, one of the practice managers at Blue Sky Dental. I spoke with her and her co-manager Vicki McKay in the practice conference room, a bright and roomy meeting space on the first floor, with a flat screen video unit on one wall and a large internal window overlooking the reception area below.

"When we first saw the building it definitely ticked some boxes in what we were looking for," says Vicki. Among those boxes was a location in an "up and coming" part of town near the new train station. The building also sits on one corner of a large retail park with ample free two-hour parking for patients – the lack of which was another drawback of the former practice on George Street.

But it was the potential offered by the 4,000 square feet of space that was most exciting. In its former incarnation as a clothing outlet the building had been used primarily as a shop floor downstairs with stock and storage areas on the first floor. Here Dr Macleod and his managers envisaged a ground floor reception area, surgeries and support rooms. Upstairs was ample space for admin and staff functions.

"With much trepidation," says Dr Macleod, "I set the ball rolling and entered the dark and mysterious world of commercial lawyers, architects, surveyors and, worst of all, the local planning authority."

Dr Macleod project-managed the design and renovation of the building himself with the help of Kerry and Vicki and he also came up with the name Blue Sky Dental – this being a nod to how he encouraged his team to think of what was possible with the new venture. Many months of planning and design followed with the team drawing inspiration from the internet and also by visiting other practices having undertaken similar projects. Approval for the building work came through in December 2010 and work commenced on the site in early January 2011. Six months later Blue Sky Dental opened its doors for business.

The final result is certainly unlike many UK dental practices – a refreshingly bright and airy interior, uncluttered and almost minimalist. On the ground floor are five full-sized

Kerry Lambie (left) and Vicki McKay

surgeries and a large front patient waiting area and reception separated by a glass wall that fills the interior with light from the large shop-front window.

Among the other rooms is a spacious and fully equipped LDU and a dedicated ortho-pantomogram suite for taking full-mouth radiographs and a separate X-ray processing room. The upper floor is reserved for two business offices, a staff room for lunch and tea, staff toilets with a shower and lockers, the dedicated video conferencing and training room, store and equipment rooms.

> "THE FINAL RESULT IS UNLIKE MANY UK DENTAL PRACTICES - A REFRESHINGLY BRIGHT AND AIRY INTERIOR, UNCLUTTERED AND ALMOST MINIMALIST"

NEW LOCALE, NEW WAYS OF WORKING

Not only was all the dental equipment fresh out the box – from the Belmont Clesta II chairs and individual surgery Durr suction motors to the phosphor plate digital processing unit – the practice also purchased new software that has changed the way it manages patient records, the aim being a "paperless" office.

"In the old system we kept paper copies of all the records," says Kerry. "Now we scan the letters we get so we don't need to keep hard copies. Our X-rays are also scanned directly into patient files."

The software (SOE EXACT) also incorporates features like pop-up messages and automated email and texting for recalls and appointment reminders that have reduced patient DNAs. The practice plans soon to introduce email booking.

Another welcome change for Kerry and Vicki is the benefit of having business offices on the first floor. Says Vicki: "At the old surgery we didn't have a room for management duties so were always carting box files about. It's fantastic now to have a base." Not only do the offices provide a quiet place to work they also offer privacy in dealing with HR matters.

The larger staff room has also made a difference to practice morale. "It's big enough for everybody to have lunch or tea together," says Kerry. "The staff room in the other practice was so cramped it was like two in, two out."

And the larger conference and training room means that the practice can now invite trainers in to offer courses to all the staff at once and with the possibility of video conferencing for remote training.

Has the move been successful for the business? In just over a year since relocating the practice has picked up 3,200 new patients which brings the total list to over 10,000. This can be attributed in part to the high visibilty of the practice at its new site. To accommodate the increased demand a new associate dentist has been hired and one of the other associates has had to up her hours.

"Although this is a dedicated NHS practice, my goal was to equip the new surgery to a standard that a private practitioner would be proud of," says Dr Macleod.

"I am very proud of what has been achieved and have been delighted by the positive reaction from everyone, staff and patients alike."

A change of scene can make a big difference , adds Vicki. She recalls the first day the new practice opened. "It was a completely different feeling coming through the door – much brighter and exciting. I think it gave everyone a new lease of life."

Jim Killgore is an associate editor of MDDUS Practice Manager

Safe repeat prescribing –make it happen

ONE area of indisputable risk within general practice is the management of repeat prescribing systems. Most practices have evolved a system which is heavily reliant on both their patient IT system and the human-user interface. All will have certain strengths and risks and when they fail can result in harm to the patient and the possibility of a complaint or claim of negligence.

A recent study commissioned by the GMC looking at prescribing or monitoring errors within general practice found they occurred in one in every 20 prescription items. They found the errors could be attributed both to the prescriber or the patient, the team, the working environment, the task, the computer system and the primary–secondary care interface.

The role of the practice manager is essential in ensuring that repeat prescribing systems are robust. Safe repeat prescribing can be achieved where everyone involved (patients, receptionists, GPs, practice nurses) understands the importance of their role, the associated risks and how each impacts on the other. In addition, it is important that information is accurately recorded within the patient system, and that there are regular and prompted clinical reviews of each prescribing record. Training on consistent use of the patient system and effective team-working are crucial to support patient safety.

Although each practice will have their own systems in place, and each will be different, MDDUS sees patterns associated within claims of negligence each year where systems have failed and contributed to patient harm. These patterns highlight often avoidable risk and are discussed below.

LACK OF MONITORING

Past or acute medication requests

There are often clinical reasons informing a GP's decision not to add an item to a patient's repeat prescribing record, and any requests from patients for an item which is not available on the record should be treated differently. The system should ensure that the GP is notified when items are not on repeat and this should prompt an active decision to re-authorise the item. This lack of a prompt is compounded when a practice delegates responsibility to non-clinical staff for preparation of the prescription for signing. Failure here can result in the patient receiving medication for too long without clinical review.

System output information

The clinical team should work to ensure that all new repeat prescription items are added accurately, taking into account the nature of the medication, how it is to be used and how often it should be reviewed. Any new drugs should be added into the context of the whole picture, which should result in more efficient management of each patient's repeat

prescriptions. Time taken in this initial stage will ensure that the patient system delivers useful information at the time of prescription preparation, such as warnings of possible non-compliance or overuse of items, as well as prompts for necessary re-authorisation of items.

Where consistency is not applied in item entry, or where the task of adding items is delegated to a non-clinical team member, practices are likely to receive a high number of 'useless' or inaccurate prompts from the patient system. This can result in these being ignored by the team. In investigation of any failure of repeat monitoring, the practice will certainly be asked why they did not use the patient system in a reasonable, effective way to ensure patient safety.

CONTRAINDICATIONS AND INTERACTIONS

MDDUS often assists practices with claims of negligence where patients have been harmed by a missed interaction, missed contraindication or incorrect prescription. These are often avoidable if information is coded correctly within patient systems, where there is a clinical overview of any additions or changes to repeat medication records, or if safety prompts are added into clinical decision-making.

Reconciliation of discharge medication

There is a substantial body of evidence to indicate that risks associated with moving between sectors contribute directly to patient harm. In 2010, the Department of Health reported that 30-70 per cent of patients experience a medication error when their care is transferred. Often discharges are illegible and include complex changes to a patient's prescribing regime. A Royal Pharmaceutical Report earlier this year found that the likelihood of an elderly patient leaving hospital on the same medicines that they were admitted on is less than 10 per cent*. In addition, between 28-40 per cent of medicines are discontinued and 45 per cent of medicines are new at discharge, and 60 per cent of patients have three or more medicines changed during their stay in hospital.

Where the practice system includes both a clinical overview and an actioning of changes, the risk of error is likely to be significantly reduced. Although it is possible that clinicians may still be liable to make an error, the risk is reduced with clinical understanding. If any responsibility is delegated to non-clinical staff, doctors should ensure they are competent to undertake the task, understand the associated risks and always check and 'sign-off' the final repeat record.

Prescribing where known allergy exists

Each year, patients suffer harm when they are prescribed a drug to which they have a known allergy. Most patient systems now incorporate the capacity to code known allergies such that an automated safety prompt is triggered when a drug is prescribed. This is a useful safety net available to practices and should be used in addition to normal advice which is always to ask the patient if they have an allergy.

Accurate clinical coding of a patient's conditions and a comprehensive record of prescribing are essential to ensure appropriate safety prompts are activated when a patient's condition or other drugs might suggest a problem.

> "A GMC STUDY LOOKING AT PRESCRIBING AND MONITORING ERRORS IN GENERAL PRACTICE FOUND THEY OCCURRED IN ONE IN EVERY 20 ITEMS"

Any non-clinical staff delegated responsibility for coding should be fully trained and understand the importance of this role.

UNCOLLECTED PRESCRIPTIONS

Repeats

The fact that a patient has requested but not collected a repeat prescription can provide useful information about their compliance. In most practices, the receptionists check the 'prescription box' every couple of months for old prescriptions. These are often destroyed without action. In order to ensure the repeat prescription record is accurate, the items should be recorded as 'uncollected' and the prescriptions destroyed. This ensures that any automated prompts on prescriptions are accurate and alerts doctors to possible non- or under-compliance at the patient's regular repeat medication review.

Acutes

Negligence claims consistently arise when a patient's treatment has been unnecessarily delayed. This sometimes can be a result of maladministration of prescriptions awaiting collection. Where a GP has taken a clinical decision to prescribe an acute drug, it is important to ensure that the patient receives it. If any acute prescriptions remain for collection after an agreed time period, they should be reviewed by a clinician to agree whether further action is required, and the patient prescribing record updated – particularly if it is decided that the prescription is no longer required.

DEVELOPING A ROBUST SYSTEM

When reviewing your own practice system it is important to map out the processes in place and review whether there are any areas that could be improved. It is also important to understand how your own patient system functions and the safety features and prompts available to you should you use it fully. Ensuring competency, consistency and accuracy when entering clinical conditions and new items into patient prescribing records is critical to trigger appropriate safety information.

Practice managers should assess along with the partners who is most appropriately skilled and experienced to carry out each process in order that patient safety is supported.

Further, practice managers should ensure that the practice culture values patient safety, that workload and stress are assessed and managed and that distractions and interruptions for individuals carrying out processes around repeat prescribing are minimised. This is supported by the conclusions reached by the recent GMC study.

MDDUS ASSISTANCE

If you are concerned about your practice system and would like assistance with risk assessment, please don't hesitate to contact one of our Training and Risk Advisory team at **risk@mddus.com**

Liz Price is the training and consultancy services manager at MDDUS

* Quoted in a Royal Pharmaceutical Society Report 2011 from Department of Health 'The NHS Outcomes Framework 2011/12'

A bad combination

Day one

A GP is called to attend a diabetic patient at home. Mr Q has for the past 24 hours been suffering from frequency of micturition and in the previous night has developed nausea and vomiting. His blood sugar is high.

The GP examines the patient's abdomen and asks for a urine sample. He examines the specimen visually and suspects Mr Q has a urinary infection. He prescribes a short course of trimethoprim and returns to the surgery where he arranges to have the sample sent off to the laboratory.

In Mr Q's records is a note of pre-existing conditions including ankylosing spondylitis and ongoing treatment for that condition with the drug methotrexate. Treatment with trimethoprim is a known contraindication in patients on methotrexate as it can lead to acute bone marrow suppression. The practice computer system generates an automated hazard alert but the GP does not routinely pay attention to these, finding the low specificity (lots of false positive alerts) "annoying".

Day three

The surgery receives a phone call from Mrs Q to say her husband has been taking the prescription for two days but his condition has grown worse with further nausea. Later that day the GP phones to say that the lab results indicate that trimethoprim was not the correct antibiotic for the type of infection and he issues a new prescription for cephalexin.

Day five

Mr Q's condition does not improve and he is eventually taken by ambulance to hospital. He is catheterised and passes blood-stained urine. He requires a central line and eventually, because of deteriorating renal function, dialysis. His condition continues to deteriorate and in time Mr Q ends up in the ITU sedated and on a ventilator. He develops septicaemia and it is thought that this may be due to immunosuppression caused by an adverse interaction between methotrexate and trimethoprim.

Mr Q eventually recovers but continues to suffer subsequent health problems. Later solicitors acting on his behalf begin legal proceedings alleging clinical negligence.

An expert opinion on the case is solicited by MDDUS. The expert advises that methotrexate is an immunosuppressive drug that is eliminated largely by the kidneys. In renal impairment the drug can build up to toxic levels causing neutropenia. In examining the patient notes on admission to hospital the expert finds that Mr Q was suffering from marked neutropenia not present in earlier blood tests. But he advises that it was very unlikely that much trimethoprim would have been taken and absorbed in the 48-hour period it was administered, especially if the patient had been vomiting. Nor does he believe it likely that such a limited dose of trimethoprim would play a significant role in the development of neutropenia.

In the end, MDDUS acknowledges that there has been a breach of duty in prescribing trimethoprim in the presence of methotrexate but denies that the error contributed in any significant degree to Mr Q's illness.

A few months later the case against the GP is abandoned. However, the incident does prompt the practice to undertake a significant event analysis which concludes that the practice must be more diligent in attending to hazard alerts generated by the practice IT system. A protocol is developed to ensure this is done.

KEY POINTS

- Consider potential contraindications in all prescribed drugs.
- A medical error in itself does not amount to negligence; there must also be a causative link, i.e. it resulted in harm.
- Check for contraindications to prescribing in all patients when returning to the surgery after home visits.

Alan Frame is risk adviser with MDDUS Training and Consultancy

Diary

DIARY loves nothing better than to scavenge a nice cake or three leftover from the many training sessions held here at the MDDUS office in Glasgow – just as long as there are no repulsive medical journals lying around the desk to put one off one's appetite. So what to make of the...

➔ EAT YOUR HEART OUT CAKE SHOP Last month the Pathology Museum at St Bart's in London held a three-day exhibition/event that featured a shop offering pathological specimens rendered in cake. Among the deliciously disgusting items reportedly on sale: red blood cell cupcakes, fungal toenail cookies, polycystic kidney cakes – not to mention an enormous edible skinless head. The event was curated by Emma Thomas, a freelance artist working in the "medium of cake". Over 20 cakemakers including students and academics contributed designs to help raise awareness of anatomy and disease. Thomas' next project is an edible autopsy which she plans to slice up and serve to a select audience. Count me out.

➔ TOY STORY Worrying reports have emerged again of heavy handed anti-toy infection control policies being implemented by over-zealous NHS managers that have sparked the Care Quality Commission into action. It all started when a GP practice in Surrey was reportedly advised to cut down on the number of toys in their waiting room and clean them every day in order to comply with infection control rules. Such advice has been swiftly rebuked by the CQC who say there is no need to banish toys, carpets or soft furnishings from waiting rooms in the pursuit of cleanliness. In a report in *Pulse*, the CQC said it was aware of a number of PCTs offering this misguided advice to practices but confirmed: "These are matters that are not likely to cause the CQC any concern, or lead to non-compliance with the essential standards of quality and safety." They even went as far as encouraging practices who have been advised to get rid of toys to report this to the CQC.

➔ THE JOYS OF AGEING Just when you thought getting older was all bad news, a report in the *Daily Mail* has come along to offer us hope. According to the article, there are many reasons to be cheerful about getting older. Apparently, after the age of 50 we tend to be less affected by seasonal allergies like hayfever, we have fewer migraines, we are less sweaty (thanks to shrinking sweat glands), we are more competitive and we even have better sex. Add that to fewer colds, less sensitive teeth, increased happiness and better stamina and middle age is starting to sound positively appealing. Just don't mention creaky joints, bad backs and the menopause...

➔ MEDICINAL CHOCOLATE On the subject of keeping healthy, an Australian study published in the *BMJ* revealed dark chocolate has antihypertensive, anti-inflammatory, antithrombotic and metabolic effects, which are attributed to its high polyphenol content. Research suggests regular consumption reduces systolic blood pressure and plasma cholesterol concentrations. The study explores the rather ludicrous prospect that eating dark chocolate could be cost effective in the primary prevention of cardiovascular events. While it isn't as effective as statins or ACE inhibitors, this may be offset by better compliance and fewer adverse effects. Prescription for Bourneville, anyone?

➔ YOU'RE ALL FIRED... NOT REALLY Sacking a staff member must be one of every manager's least favourite tasks. So spare a thought for the HR department at insurance company Aviva. With one absent-minded click of a mouse, an email intended for a single employee was accidentally sent out to the entire 1,300-strong workforce. Imagine their horror upon opening the message which ordered them to hand in keys and passwords before exiting the building, while curtly warning them not to take any confidential information with them. Fortunately, mass panic was averted when the mistake was spotted and a follow-up email was quickly sent out to clarify. One can only hope the confusion was cleared up before any disgruntled employee had taken the opportunity to respond with their own rather more fruitily-worded farewell note. Source: Law At Work

➔ FORGIVENESS THERAPY Holding onto old grudges could be bad for your heart, new research suggests. A study reported in the *BMJ* claims forgiving could bring about cardiovascular benefits. Blood pressure and heart rate were measured in 202 people while they were thinking about a previous offence from an angry or forgiving perspective, or while they were distracted. After five more minutes of distraction, participants reflected on the offence. Compared with those who looked back in anger, those who looked back with forgiveness significantly stopped fluctuations in blood pressure both initially and some time later, potentially offering "sustained cardiac protection".

➔ GIE US A FIVER Or to the non-Glaswegian – hand over my five dollar consultation fee, please. This is apparently how much an 87-year-old family doctor in Rushville, Illinois has been charging his patients per visit since the 1970s. Dr Russell Dohner has become something of a national hero in the US where the Supreme Court recently voted to uphold the Affordable Care Act that limits future healthcare costs. These can be crippling, with a family of four dependent on an employment-based insurance plan expected to pay $20,000 – or about 40 per cent of median household income – on medical expenses each year. That's not to say Dr Dohner is completely immune to inflation: before the 1970s he charged two dollars a visit.

CALL FOR DIARY ITEMS Do you have any tidbits, anecdotes or absurdities in a similar vein to the items above? Please write in or email them to **PM@mddus.com**

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