First Defence

JMO'S + DOCTORS IN TRAINING

MDA National

5

WINTER 06

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MDA NATIONAL

MDA NATIONAL INSURANCE PTY LTD

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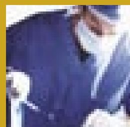
01: Editorial

We are pleased to present the first issue of *First Defence* for 2006. As usual, we have included some case studies relevant to junior doctors and hope that you find them useful as part of your own risk management education.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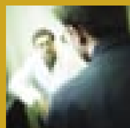
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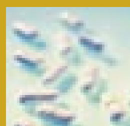

09: medical errors

At MDA National, we find that the most common areas of confusion and error for junior doctors are the events surrounding a Coronial and medication errors. With these in mind, we have included two case studies that particularly address these areas of medico-legal concern.

At this time of year, many junior doctors are assessing their existing indemnity policies and considering their needs for the coming year. MDA National Insurance has made some exciting changes to their categories and policy details to deliver greater benefits to junior doctors holding an MDA National Insurance Professional Indemnity Insurance Policy. The article on Surgical Assisting addresses just one of those.

For further information about the specific features and benefits of the policy, please contact your State Liaison Manager or Client Services on 1800 034 466 (WA) or 1800 011 255 (all other states).

We hope you enjoy this issue of *First Defence* and find the information useful. If you have any suggestions for articles or case studies in future issues of the magazine, please don't hesitate to contact me at cleonard@mdanational.com.au

Claire Leonard
Communications Manager

02: Increased Billings Limit for Surgical Assisting while in Training

From 1 July 2006, MDA National Insurance policyholders in the Post Graduate Years 1 to 4 and Doctors in Specialist Training categories will be able to generate up to $50,000 of Gross Annual Billings from Surgical Assisting with no change required to their category and no additional premium payable.

This change applies to those Gross Annual Billings generated outside an accredited training programme. Registrars can continue to generate unlimited private billings within their training programme.

Where your Gross Annual Billings exceed the specified limit, you will need to select the appropriate category from the General Practice or Physician/ Surgeon categories.

Surgical Assisting

The primary role of the Surgical Assistant is to facilitate the safe and efficient performance of an operation by the primary surgeon. It is expected that the surgical assistant will only work under the direct supervision of the primary Surgeon and will not undertake any procedures separate to, or in addition to, the main purpose of the operation.

It is accepted that it may be necessary, on occasions, for an assistant to temporarily continue with the operation or maintain a stable operative field if the primary Surgeon were to take a short break, particularly during long operations.

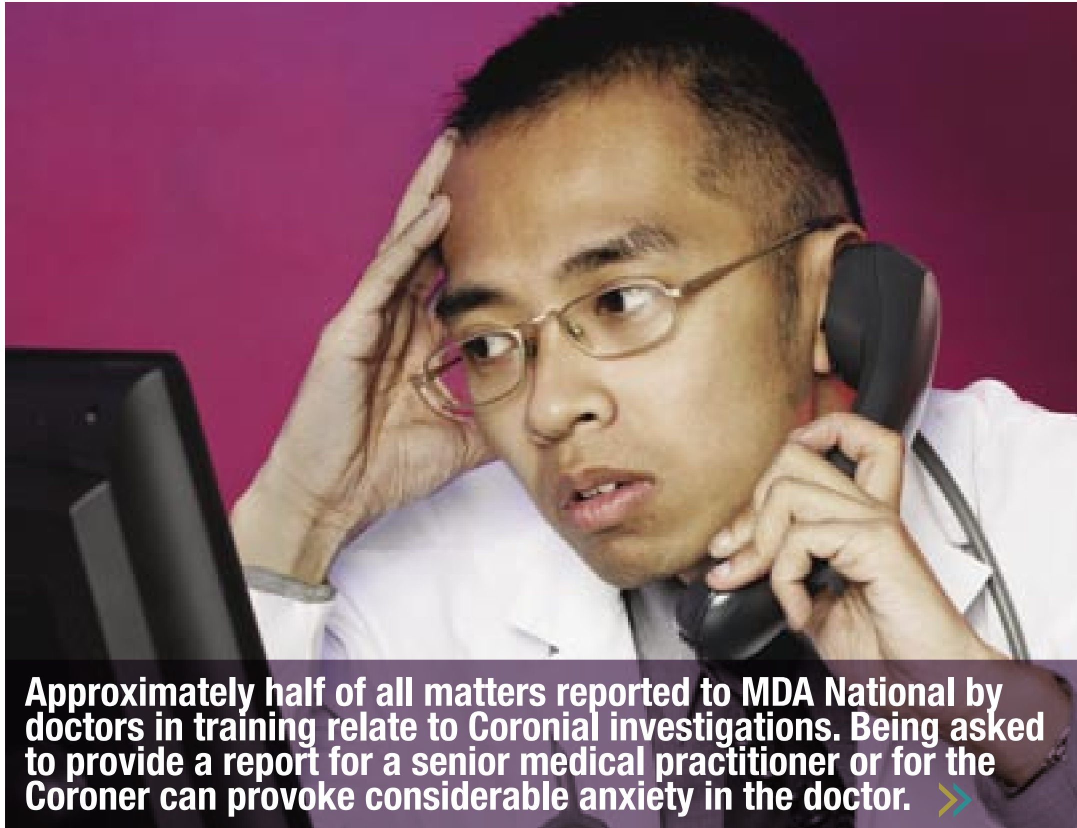
The following procedures are included under Surgical Assisting:

> Positioning of the patient
> Insertion of catheters
> Application of drapes
> Gentle exposure
> Clamping and dividing of blood vessels
> Ligating blood vessels
> Suturing
> Tying of knots and cutting of ligatures
> Display and/or dissection of anatomical structures
> Resection of bowel and/or the removal of organs or other tissues
> Anastomosis of bowel, blood vessels or other hollow tubes
> Repair of severed nerves
> Creation of artificial openings or stomas
> Manipulation and subsequent stabilisation of bones or soft tissue
> Taking and performance of skin grafts
> Insertion of drainage tubes
> Irrigation of wounds
> Closure of wounds
> Application of dressings and/or plasters

If, as a Surgical Assistant, you perform any duties that are not included on the list above, please check with Client Services to ensure you will be covered in your current category.

For more information, please refer to the MDA National Insurance Risk Category Guide 2006/07 or contact Client Services on 1800 034 466 (WA) or 1800 011 255 (all other states).

 Coronial Investigations and Documentation



Approximately half of all matters reported to MDA National by doctors in training relate to Coronial investigations. Being asked to provide a report for a senior medical practitioner or for the Coroner can provoke considerable anxiety in the doctor.

You will be asked to recall events and as this case study demonstrates, it is often the documentation of the patient consultation that proves most useful in confirming the events that took place.

Dr Prince was an Emergency Registrar at a busy metropolitan hospital. A 32 year old male presented to the Emergency Department (ED) on a Saturday afternoon complaining of cold-like symptoms and feeling generally 'unwell'. He had a recent history of surgery to remove a brain tumour (discharged 8 weeks ago from the same hospital).

The surgery had been complicated by infection which had been successfully treated with intravenous antibiotics. Dr Prince obtained a two day history of an upper respiratory infection, with a runny nose and sore throat. Over the past few hours, the patient had started to experience a dry cough. There was nil report of headache or neck stiffness. On examination, temp: 38, operative wound appeared normal and non-infected and was not tender to palpation. Neurological exam was unremarkable. GCS 15/15. O2 saturation 98%.

Dr Prince considered an infective process and took blood, urine sample and ordered a chest x-ray. Results: Chest x-ray NAD, urine NAD, slightly raised WCC. Dr Prince then consulted with the Emergency Physician to see if he thought treating the patient for a presumed respiratory infection was reasonable given the patient's history.

The consultant agreed with the provisional diagnosis and the patient was prescribed antibiotics and advised to return for assessment should he experience a headache or if any of his symptoms changed.

The patient returned home accompanied by his flat-mate. That night he died.

Dr Prince received a phone call the next day advising him of the situation and asking him to meet with the Head of Department. Dr Prince telephoned MDA National to discuss the matter; his greatest concerns were:

> Did I miss the signs of an early brain haemorrhage or infection?

> Should he have been admitted?

> Should he have had a cerebral CT scan or a lumbar puncture?

> Could I have saved his life?

In particular, Dr Prince noted to the medico-legal advisor that the patient had expressed a very strong desire not to be admitted into hospital as he had found his previous stay quite traumatic.

Dr Prince was concerned that his clinical judgement may have been influenced to a degree by trying to be 'kind' to the patient.

The discussion between Dr Prince and the Head of Department went well and there was an open and non-judgemental discussion of what had occurred. The Head commended Dr Prince on his thorough assessment and documentation - including detail of the comprehensive neurological examination, the documentation of the advice provided to the patient and details of the conversation he had with the Emergency Physician. Dr Prince was asked to draft a report for the hospital and to await the autopsy findings. MDA National assisted Dr Prince in drafting this report; a fairly straight forward task given the recency of the event and the thorough and detailed patient notes.

As the cause of the patient's death was unknown, the matter was reported to the Coroner. The autopsy report revealed brainstem and cerebellar ischaemia with associated oedema. It was most likely due to a low grade infection following the surgery.

Dr Prince continued to have some self-doubts, which is a normal reaction to such an unexpected event. His medico-legal advisor suggested to Dr Prince that he may find it beneficial to discuss his concerns with his colleagues. The ED Head arranged a meeting between themselves and the patient's Neurosurgeon where Dr Prince was able to de-brief and receive further reassurance that his assessment and diagnosis had been appropriate.

Dr Prince was told that he should contact MDA National again if there were any further developments or if he had any concerns. In particular, he was advised to seek assistance if he was asked to prepare a statement or report for the Coroner. Ultimately, Dr Prince did not receive a request for a statement or report to the Coroner and there were no further developments.

Volunteer Organisation Information

www.medicineuncharted.org
www.australianvolunteers.com
www.msf.org

Travelling overseas to volunteer your medical services is becoming a very popular option among the junior doctor population. MDA National interprets volunteer work to mean you will not receive any financial reward for the medical services you provide.

MDA National has always recognised such worthwhile work by providing you with indemnity for such activities. To be covered for this type of work, you must be a member and hold a current MDA National Insurance Professional Indemnity Insurance Policy. Then all you have to do is notify us of your plans in writing (email is fine) providing the following information:

- Where you are going
- Name of Volunteer Organisation
- Dates of your volunteer project
- Type of work you will be engaged in
- Contact details while away

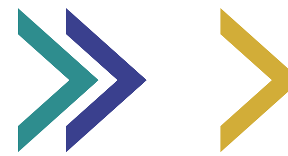
Once the information is approved by our Underwriting Team, we will provide you with written confirmation of cover for this work. You can request cover for work overseas for periods of up to one year and be covered for volunteer work any where in the world. From 1 July 2006, exclusions will no longer apply to work in Canada but they will still apply to the USA.

If you are away between May and July, please make sure we have alternative contact details for you in order to send your Renewal documentation. You will need to renew your policy to maintain cover with us.

Upon your return, drop us a line to notify us of any new contact details we need to be aware of. You should also check you have the right level of indemnity to recommence work in Australia.

For inquiries or more information call Client Services on 1800 034 466 (WA only) or 1800 011 255 (all other states). If you do not currently hold a policy with MDA National Insurance, please call Client Services to discuss further.

Confessions Regarding a Criminal Act



A regular psychiatric patient presents at a large public hospital and during the course of the consultation with Dr Barnes, the Psychiatric Registrar, tells a story of having committed a murder and disposing of the body in a river.

The patient requests that Dr Barnes keep the information confidential, she agrees but notes in the clinical records the contents of the patient's "confession". The gravity of this information given by the patient distresses Dr Barnes and she confides in the VMO.

The VMO examines the patient and warns the patient at the outset that he is aware of the history regarding the confession to Dr Barnes and indicates that if he had been given the same history, he would not consider himself bound by confidentiality in relation to the information. The patient does not repeat "the confession".

Was Dr Barnes correct in not divulging the information to the Police? What obligation does she, the VMO or the Hospital administration have to bring the confession to the attention of the Police?

Health Care professionals are well aware of their long standing Duty of Confidentiality.

There is a long standing ethical and legal obligation to maintain patient confidentiality.

However, there are exceptions to the rule. They are:

> the patient has given consent; or

> mandatory disclosure under compulsion of law e.g. child abuse, common notifiable diseases;

> pursuant to the direction of an Officer of the Court e.g. subpoena.

Both Dr Barnes and the VMO could have breached the patient's confidentiality. They have an overriding duty in the "public interest" to disclose information where it is "necessary to prevent or lessen a serious or imminent threat to an individual's life, health or safety, or a serious threat to public health and safety". As the VMO was not advised directly by the patient he is relying on hearsay. However, as it was written in the clinical records it would have been advisable for him to contact his medical indemnity insurer and seek advice before he notifies the police.

This exception is outlined in the National Privacy Principles, in particular, NPP2. This outlines the medical practitioner's obligations when using and disclosing health information.

If you are ever advised by a patient that they have committed a criminal act, you can breach that patient's confidentiality on the basis of this exception. It is recommended that you seek always advice from MDA National prior to breaching a patient's confidentiality.

Medication Errors

Medication errors usually occur as a result of a breakdown in a system of health care delivery. Studies indicate that one third of adverse drug events are preventable. For every preventable adverse drug event, there is likely to be three times as many near misses.

Medication errors occur most frequently at the ordering and administration stages.

So what are the most common issues in relation to medication errors in hospitals?

> Wrong drug
> Poor response to treatment
> Similar names
> Wrong dose
> Staff fatigue
> Incorrect drug
> Stress
> Wrong patient
> Wrong concentration
> Wrong method of administration
> Look alike drug
> Verbal check
> Wrong time

Case Study

A 68-year old male patient had undergone an uneventful right coronary angioplasty. He required a removal of the sheath which was inserted into his femoral artery and vein. In order for the sheath to be removed, 100mcg of Fentanyl, 600mcg of Atropine and 15mls 1% of Lignocaine were to be administered. This medication was ordered by the RMO who was going off duty at 7pm.

She had written the drugs under "the Short Order", a telephone order treatment sheet and had also written the drugs under the "Pre-medication Orders" treatment sheet. All the drugs were drawn up by nursing staff.

Dr Clark came on night duty at 9pm and administered the Lignocaine, he did not order or sign the patient's medication chart. Nor did he check the vials of Fentanyl or Atropine and was not shown any syringes containing the Fentanyl or Atropine by the nursing staff. Dr Clark also failed to check the medication chart.

Dr Clark administered the Lignocaine to the patient's groin and he instructed the nurse to administer the Fentanyl and Atropine. He did not observe the nurse administer these drugs.

The two Registered nurses readily checked the doses and amount to be administered and this was performed. The patient was given 500mcg of Fentanyl intravenously by the nurse, not the 100mcg which was ordered.

The patient died and both Dr Clark's and the nurse's account of the conversation regarding the amount of Fentanyl to be administered, was at issue.

One Registered nurse stated to her colleague that Dr Clark had told her to "*give all the dose of Fentanyl as a bolus dose*". He disputed this. The medication chart stated 100mcg of Fentanyl to be administered and 600mcg of Atropine. Both Dr Clark and the nurse had differing accounts of the conversation regarding administering the Fentanyl. The nurse maintained that she verbally checked with Dr Clark if 500mcg was to be administered and he had confirmed that it was.

How could this outcome have been avoided?

All staff must be conversant and aware of the policies and procedures related to checking and administering medication. There must be consistent usage of medication charts in all hospitals. Always write legibly use protocols and checklists. Medication charts are to be regularly checked by a pharmacist. This reduces the errors and allows accurate interpretation of orders by all members of staff.

The medication charts are to reflect this practice i.e. the dose, the amount, the method, the administration must be clearly written and signed by the prescribing practitioner on the appropriate medication chart.

It is essential that medications are always checked with a colleague before they are administered.

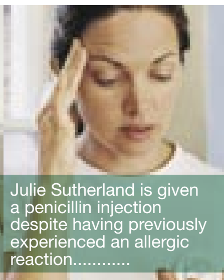
If a doctor is asked to verbally confirm the dosage or type of drug to be administered and you have not prescribed the drug you must check the treatment sheet first.

If a doctor or nurse is required to administer a drug they **must** check the treatment sheet with the patient and determine that the drug that has been drawn up or that is to be dispensed is the appropriate drug and amount to be administered. **Always** double check before administering any medication.

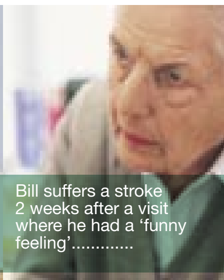
11:

Baby Jacinta receives the wrong vaccination from the practice nurse..............

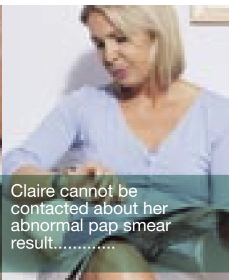
Despite Mr Ibrahim's regular visits, his diabetes is out of control...........



Julie Sutherland is given a penicillin injection despite having previously experienced an allergic reaction............



Bill suffers a stroke 2 weeks after a visit where he had a 'funny feeling'.............



Claire cannot be contacted about her abnormal pap smear result............

This sounds like a bad day for any practice!

Mistakes are defined as errors of intention; failing to follow a rule, choosing the wrong one or simply not knowing what we are doing. Adverse events are rarely the result of a health professional providing poor quality care and when a mistake occurs, the question should not be 'whose fault is it?', but 'why did the system fail?' It is important that all adverse events are investigated, the risks identified and the opportunity taken to change a system or put controls in place to avoid the same incident from occurring again.

MDA National and the RACGP have collaborated on a series of GPLearning modules that address these components of risk management. The aim of these modules is to educate GPs by providing easy to implement, high impact tools that identify risks and their causes.

The modules are presented in an interactive manner and include audio and visual material, case studies, self-reflection question and answer segments and reference material with links.

The modules will be available on the GPLearning site in early June 2006. All MDA National members will have free access through the Members Only area of the MDA National website.

www.mdanational.com.au www.gplearning.com.au

Freecall: 1800 034 466 (WA) **1800 011 255 (all other states)**

Email: peaceofmind@mdanational.com.au **www.mdanational.com.au**

Perth

Level 3 516 Hay Street
Subiaco WA 6008

Ph: (08) 6461 3400
Client Services Fax: (08) 9415 1493
Client Fax: (08) 9415 1492

Melbourne

Level 1
101 Dundas Place
Albert Park VIC 3206

Ph: (03) 9915 1700
Fax: (03) 9690 6272

Sydney

Level 5, AMA House
69 Christie Street
St Leonards NSW 2065

Ph: (02) 9023 3300
Fax: (02) 9460 8344

Brisbane

Level 8
87 Wickham Terrace
Spring Hill QLD 4000

Ph: (07) 3120 1800
Fax: (07) 3839 7822

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