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Medical Protection Society

Auckland

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17:00 - 18:00 Common Issues Faced by Practice Managers - Staying Out of Trouble and Ahead of the Game

# GP CME ROTORUA 2017

# COMMON ISSUES FACED BY PRACTICE MANAGERS - TIPS FOR STAYING OUT OF TROUBLE AND AHEAD OF THE GAME

Dr Andrew Stacey, MPS Medical Adviser

# What will we be discussing?

1. Complaint management
2. Dealing with difficult patients
3. Privacy issues

# 1. Complaint management

- Understanding the Practice's obligations under the Code of Rights
- Discussing an approach to managing complaints

# Guiding principles of good complaint handling

- Getting it right
- Being customer focused - trying to put things right
- Being open and accountable
- Acting fairly and proportionately
- Seeking continuous improvement

# Pitfalls of poor complaints handling

- More work and stress
- Damage to Practice's reputation
- Escalation to HDC
- Failure to learn…more complaints!

# Reasons why complaints may be escalated

- Unnecessary delays
- Response incomplete/poor explanations
- Factual errors in response
- No acknowledgement of mistakes
- Inadequate apology
- Inadequate system changes

# Obligations under the Code of Rights

- Right 10 – right for consumer to complain and duties providers have in assisting with complaints
- Providers must have a complaints procedure and follow this
- Providers must facilitate the fair, simple, speedy, and efficient resolution of complaints

# Obligations under the Code of Rights

- To have a complaints procedure where:

  - Acknowledgment within 5 days
  - Response within 10 days or consider how much more time required
  - If 20 days or more, then notify complainant why
  - Monthly updates
  - Information provided re your complaints procedures and given details of HDC/Health Advocates
  - Documentation of complaint and actions taken
  - Complainant given all information relevant to complaint

# Obligations under the Code of Rights

- The response must give:
  - Reasons for the decision
  - Proposed actions
  - Appeals procedure

# How to deal with a complaint

- Log the complaint – register of complaint, track progress
- Confirm oral complaint in writing and check with consumer
- Is there a consent issue?
- Acknowledge within 5 working days
- Aim to resolve the complaint early to prevent escalation - example

# Case 1: example of escalation

- Mother brings 11yr old daughter to see GP registrar re migraines
- Dr prescribes metoclopramide and initially suggests she takes disprin
- Mother emails practice with complaint about prescribing and medicine recommendations on 17th December.

- Emails practice again in the evening of Monday 5th January:

> *"Glad to see as a health provider and business that you have a great complaints procedure when I sent the below complain[t] on the 17th [December] and as of today I have had [n]o response, not even an acknowledgement."*

- Website submission to HDC in evening of 6th January. Complaint starts with:

> *"Below is email sent to [practice] on 17.12.14 to which no response has been had. I sent a further e-mail last night complaining about the lack of communication from them following my complaint including them not even acknowledging."*

- HDC acknowledged that the complaint had been made at a busy time of the year (prior to xmas) but was of the opinion that the delay in acknowledging and responding to the complaint was unacceptable.

- Opportunity missed to resolve the complaint at an earlier stage. GP registrar ended up being breached by the HDC.

# How to deal with a complaint cont.…

- Consider:
  - Who is the most appropriate person to respond to the complaint?
  - Who needs to know about the complaint and have input into the response?
- Risk assess the complaint so that any investigation is proportionate to risk:
  - Why the disparity between what happened/should have happened?

# How to deal with a complaint cont.…

- Talk to or obtain statements from everyone involved
  - Staff should feel supported and involved
  - Coordinated response where multiple clinicians involved

# How to deal with a complaint cont.…

- Refer to relevant notes or policies
- Highlight any failures, clinical or administrative.
- Identify what action is being taken as a result.

# Structure of the response

- Contact your indemnifier early

- Be mindful where the response could end up
  - Factual, objective content.
  - Avoid personal opinions and accusatory statements

E.g.:

**not** “You were aggressive and intimidating”

**but** “I found you aggressive and intimidating.”

# Structure of the response

- Identify the issues raised in the complaint
- Sympathetic opening paragraph
- Explain how matter has been investigated
- Summarise issues raised

# Structure of the response

- Clear account of the events
- Address issues raised in complaint
    - Grouping into themes
- Conclusions and changes in practice
- Offer to meet or address outstanding issues
- Details of the HDC/advocacy services

# But it could still all go wrong.
# Its not just what we say, but also how we say it…

- I am sorry that I cannot respond to your questions regarding the part played by the locum as she has now left the practice.
- I refute the allegation made that ……
- I hope you are satisfied but if not you can register with another practice.

# Common underlying themes in complaints

- COMMUNICATION - Investing time to keep patients and relatives informed and providing accurate, consistent and complete information.
- ATTITUDE - Treating patients and families with compassion, respect, dignity and sensitivity .

# The four Cs

- Compliments
- Comments
- Concerns
- Complaints

All provide feedback on service provision

# Learning from your mistakes

- Reduce chance of recurrence
- Share experiences with others e.g. Practice Manager meetings and Practice meetings.
- Close the loop following feedback from patients -

*"You told us you wanted…so we have done…"*

# Case 2: A request to change doctors

- PM receives complaint on 11 March. Pt dissatisfied with care received from one of Drs in practice.

- 3 February
    - Pt phoned practice and spoke with PN. Had lost confidence in Dr and wanted to see another Dr in practice (preferably a female).
    - Pt left with understanding that nurse would discuss this with PM.
    - Later that same day Dr rang her. Pt upset about receiving call as had advised that wanted to see another Dr.

- 20 February
    - Pt phoned practice and reiterated wish to see another Dr.
    - Advised that it was practice policy that pts could not see another Dr unless the PM agreed.
    - Advised that PM would contact her.

- 23 February
    - PM rang pt. Advised that could only see another Dr if usual Dr was away or sick.
    - Request to transfer Drs could not be considered until March when they would know how many pts had left the practice and what spaces were available.

- 4 March
    - Pt requested assistance of Health Advocate and rang PM.
    - PM offered for care to be transferred to another Dr.
    - Pt said she would have been happy with this Dr but in the meantime had transferred out of the practice and back to her previous GP.

# Pt's concerns:

Even though I had expressed concern to a practice nurse and eventually the practice manager, there was no exception made for me to consult with another GP at the practice and gain a second opinion and further investigations.

Even though I acknowledge that the practice eventually offered for my care to be transferred to another GP within the practice, I was effectively left with no GP and was forced to change practice.  This offer came approximately two weeks after being told I could not transfer to another GP and such a transfer could not be considered until March.

From this I would like to be left with the knowledge that [X Practice] had re-evaluated their policy of allowing patients to see another GP within the practice when a request is made to do so.

That when a client expresses concern with the care they are receiving from a GP and request[s] to be transferred under another GP with the practice, that this is considered in a timely manner.  If it wasn't that I was forced to transfer to another practice to get the investigations I needed, I would have accepted the offer of having my care transferred to Dr [B]. But I am very happy with my new practice and will remain with them."

# How would you have responded to this complaint?

## Need to

1. Acknowledge the patient's frustrations.
2. Address concerns about care received from Dr (in this case the Dr was not interested in responding).
3. Explain the process for reallocation of patients and the reasons for this policy.
4. Explain the actions the PM took to address the patient's concerns.

# Practice manager's response

As a Practice Manager, I can not discuss treatment given by Dr [A] as I am not medically trained.  I have passed your letter on to Dr [A], and he will consider your points in future choices.

Our policy is to review our patient numbers every three months to see whether the doctors can take on more patients, this includes internal transfer of patients in the practice. The reason for this is that the practice is currently running to capacity. Each doctor can only care for a certain number of patients without comprising access to, and the standard of, medical services, and they have reached their limits. For this reason we are not accepting new patients.

Every three months we get updated enrolment data about the number of patients under each Doctor. When I receive this data, I then consult with each doctor about whether they are able to accept new patients; either from outside the practice, or patients within the practice who wish to transfer doctors.

When I spoke to you on the 23rd of February I explained this to you. I also informed you that I would need to get approval to transfer you over to another GP in the Practice.

Due to your call and distress, I also said then that I would ask Dr [B] if she would take you on due to these special circumstances. Dr [B] did agree to be your GP, so I contacted you about this on the 4th of March. At that point you informed me that you changed back to your old GP and would prefer to stay there. I am sorry that you feel I could have done this faster, but due to the hours I work, it is sometimes difficult to reply immediately.

I do apologise on behalf of the practice for any distress caused by our actions and wish you all the best for the future.

# What could have been done to have perhaps avoided a complaint (focusing just on the request to change Drs)?

# What could have been done to have perhaps avoided a complaint?

1. More flexibility
    - Reasons for Practice's policy are understandable, but appear a little inflexible; especially given pt is dissatisfied with the care received from one Dr and is seeking a 2nd opinion.

2. Avoiding excessive delays
    - 20 days between pt. first notifying Practice of their concerns and PM becoming involved.
    - Further 9 days until offer of alternate Dr made -
        - involvement of PM earlier
        - keeping pt. informed about progress

## 2. Dealing with difficult patients

- When and how the patient can be disenrolled
- Boundary setting

MPS

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# Ending a doctor-patient relationship

*If you want to end a doctor-patient relationship with a patient it must be done in a professional and fair manner. You may only end the professional relationship if you are confident that the patient is not acutely in need of immediate care or that care of the patient has already been accepted by another doctor.*

# Guidance from MCNZ Statement

- If you decide to discontinue a doctor-patient relationship then you must be able to justify the decision.
- Assist the patient to locate an alternative doctor and/or to give the patient sufficient notice so that he or she can find another doctor.
- In situations where there is any possibility of a complaint from a patient it is advisable that you contact your medical indemnity representative before initiating the process to discontinue care for the patient.

# Guidance from MCNZ Statement

- The process to the end the professional relationship must be clear, so that the patient no longer has any expectations of continuing care
    - Tell the patient that the professional relationship has ended and the reason why.
    - Note the termination in the patient's records.
    - Refer the patient to another doctor of the patient's choice and send a referral letter (or reporting letter) to that new doctor.

# Boundary setting

## Meet with the patient to discuss your concerns:

1. Give examples of these concerns

2. Outline your expectations going forward
    - refer to practice policy as appropriate

3. Outline the consequences if the behaviour continues.

Follow up the meeting with written communication reinforcing the above.

# Case 1

- Practice faced with patient who swears at staff members and has displayed threatening behaviours.
- MPS asked to review the following letter which they intend to send to the patient.

What are your thoughts about the letter?

What, if anything, would you have done differently?

This agreement is drawn up between the above parties to ensure a therapeutic pt./doctor relationship moving forward. It recognises ALL the patient rights and REASONABLE requests…

The providers (GP and Practice nurses) would reasonably expect behaviour in line with the general norm i.e. no swearing, causing duress or any threatening behaviour however subtle.

The above agreement is purely for therapeutic report to be improved, but also gives either party reasonable grounds to terminate the relationship, should this ever become necessary after agreed and bilaterally acceptable negotiation as per the College and Counsel standard.

Patient:

Doctor:

Witness (Practice Manager):

Date:

- Formal agreements just that – too formal and stilted.
- Some patients may have had difficulties understanding the letter.
- Better if practice met with patient and:
    - gave examples of concerning behaviours
    - set expectations
    - discussed what would happen if the behaviour continued.

# Case 2

- Practice had a difficult patient:
  - Repeated comments about substandard care
  - Not courteous to staff
- The practice had just put up with these behaviours for many years but staff had reached the end of their tether.
- The Practice intended sending the following letter -

This letter is to advise you that we will no longer provide medical care to you and your enrolment with us will be terminated. This follows a complete breakdown in the doctor/patient relationship with this practice following your visit and phone calls to our staff in which you have spoken to them in a way that is less than positive, repeatedly commented about our substandard care and this has made them feel threatened.

> We have tried to offer you appointments to see our doctor which you have refused. If you have an explanation for this behaviour please respond to this letter by 04/12/2014, and your response will be taken into consideration.

In the absence of a reasonable explanation for this/these incidents we will require you to make alternative arrangements for your primary healthcare by 16/12/2014. Following is a list of practices in the [X] Region that are accepting new patients:

Please advise the details of your new doctor for us to forward your medical records to.

What do you think about their approach to the situation?

- Missed ‘setting boundaries step’ and went straight to termination.

- Patient has a right to complain/voice an opinion

- Letter does have good elements in that IF there had been grounds to move straight to termination then:
    - clear that care had been terminated
    - reasons given for the breakdown (albeit actual examples would have been even better)
    - allows for possibility that there is an alternate explanation for the patient's behaviour
    - assists the patient to find another practice and gives them a reasonable opportunity to do so
    - fulfils obligation to transfer notes on request.

- MPS advised Practice Manager to meet with patient and set boundaries.

# The Practice Manager then emailed MPS:

My next question is whether these discussions are noted in his medical record as to the unacceptable behaviour?

How would you have approached this?

- File these outside the notes but make an entry in the notes that refers to the existence of this separate paperwork.

- This way the meeting notes are not automatically transferred with the notes to subsequent providers but can be requested at any stage.

- From time to time patients have complained that the contents of their notes have created difficulties in finding another provider and feel that they are being prejudged and discriminated against.

The Practice met with the patient and set boundaries surrounding interactions with staff.

The meeting was followed by this letter:

I am writing following your appointment with Dr [A] on 01 December in which your repeated calls to our reception and nursing team about our substandard care were discussed.

These behaviours are unacceptable and Dr [A] advised you that this could not continue. We respect your right to complain about our services but this must be done in a non-threatening and non-offensive manner.

Our aim is to provide the best possible medical care for you but it is important you understand that there are certain behaviours that we do not tolerate in order to keep our Medical Centre a safe place for our patients and staff.

I have enclosed a copy of our policy on unacceptable patient behaviour. Any repeated incidents of a similar nature will result in you having to transfer out of the practice.

# 3. Privacy issues

- The Privacy Act
- Maintaining privacy in the practice
- Releasing Patient notes
- Sharing information with colleagues
- Dealing with a privacy breach

# The Privacy Act 1993

- Regulates what can be done with information about individuals.
- Requires agencies to handle personal information in line with 12 information privacy principles, which guide how personal information can be collected, used, stored, disclosed and destroyed.

# Maintaining Privacy in the Practice

- Overheard conversations
  - at the front desk
  - rooms with the doors open
  - nurses station/staff room
- Staff access to PMS
  - do admin staff need access to clinical notes?
  - do staff know when it is inappropriate to access notes?
- Information transfer
  - fax/email
  - texting patients

# Maintaining Privacy in the Practice cont.

- What patient information goes off-site?
  - doctor's lap tops, memory sticks, backup drives
- Staff confidentiality agreements
  - does it include post employment clause?
- Social networking sites
- Where are paper records stored?

# Releasing Patient Notes

## Where do requests usually come from?

- Patient
- Insurance company
- Relatives after a death
- Police/Lawyer
- CYFs
- ACC
- MCNZ/HDC

# Release with consent of patient – what are the limits?

## Can redact notes to remove

- Third party information
- Anything which may cause harm to patient or another if released

# Insurance companies

- Insurers that collect full medical notes - even for a specified period - are at risk of breaching the Health Information Privacy Code. This is because insurers can only collect personal health information that is necessary to make insurance decisions.

- Should usually take the form of asking for answers to particular questions.

- Occasionally, an insurer will be entitled to collect full medical notes…these situations should be rare

- Any non-disclosure of information that a prudent insurer might need to know can affect a person's entitlement to claim on their insurance, whether the non-disclosure was deliberate or inadvertent

- Practice needs to ensure patient has provided informed consent to release of health information

# Relatives after patient has died – who can request the notes?

- Next of kin?
- EPOA?
- Executor of the will?
- Administrator of the estate?
- All of the above?

# Relatives after patient has died – who can request the notes?

- EPOAs cease to have any relevance once a person has died.
- Need consent of Executor to release notes.
- If no Executor ? Is court going to appoint administrator?
- If no administrator – is there a practical solution?
- What should you remove from the notes before release?

# Police

- Often make their request quoting s11 of HIPC or s22C of the Health Act
- In NZ law health professionals have no obligation to report illegal activity* but do have some discretion to do so
- Safest option is to request a Production Order

# Obligation to release v discretion to release – where is the risk?

- Obliged to release if required by a Court order or a Production order or if there is any other statutory obligation (driving).
- Discretion to release – much broader but could be criticised and may be at risk of complaint.

# Releasing Patient Notes

- Would you release notes based on this request from CYFs?

> I would appreciate any information as soon as possible and am happy to have a telephone conversation, however can accept a response sent to me on my email address listed below.
>
> If you require any further details in relation to this request please don't hesitate to contact me on my details below.
>
> This information is requested under section 22 (c) of the Health Act 1956 and section 66 of the CYPF Act 1989.

- How about when they add this on the end of the letter?

> In making this request for information, I have considered the provisions of the Health Information Privacy Code 1994. I believe that the disclosure by you of the information that I have requested will not breach the Health Information Privacy Code 1994. Access to the information I have requested is necessary for the purpose of investigating a notification and ensuring the safety and welfare of a child/young person, in accordance with the Children, young Persons and their families Act 1989. Please refer to rule 11, (2)(i) of the Health Information Privacy Code 1994.

- ACC
    - ACC45 provides consent for release of information relating to injury, be careful not to release other information without consent

- MCNZ/HDC
    - don’t need patient’s consent

# Sharing information with colleagues

- Under s22F of Health Act 1956, where any other person is providing services to your patient and requests health information that you hold about that patient, you must provide this.
- HOWEVER, you may refuse to disclose that information if you have a lawful excuse for doing so, or you have reasonable grounds to believe that your patient does not wish for this to occur.
- In most situations don't share information if patient does not agree
- Need systems to ensure patients know how information will be shared between clinicians
- Consider seeking patient's permission to share information

# When there has been a privacy breach

- Call your indemnifier
- Limit harm
- Do you inform the patient concerned?
- Possible consequences

# Remember

- Privacy issues are complex.
- Even with best intentions, it is easy to slip up.
- If in doubt about either keeping or releasing information contact your indemnifier.

# MORE THAN DEFENCE

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