NOTTINGHAMSHIRE LMC
Local Medical Committee (Limited)

Brieflet

Requests made of GPs by patients:

When to visit?

A Nottinghamshire LMC Ltd guide on visiting patients

"The investigations or treatment you provide or arrange must be based on the assessment you and the patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options."

GMC, Good Medical Practice

Introduction

According to 'Good Medical Practice' GMC (2010) 'Good Clinical Care' must include:

"a) Adequately assessing the patient's conditions, taking account of the history (including the symptoms and psychological and social factors), the patient's views, and where necessary examining the patient…"

It further states, under the heading 'decisions about access to medical care'

"7. The investigations or treatment you provide must be based on the assessment you and the patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of treatment options."

The following guidance, which is not meant to be definitive, seeks to give practical expression to those principles.

General Considerations

It is axiomatic that, as a GP, you must always put yourself in a position to make a proper assessment of your patient's condition. Using your judgement and experience, you must ask the right questions of the patient to reach a diagnosis which is defensible, medico-legally, that means, would be regarded as acceptable by 'a reasonable body' of general medical practitioners (as per the famous Bolam test), but which is also, in the eyes of a court, judged, objectively, to be *logical* and *reasonable.*

When you decide a visit is not necessary, you must not only explain your reasoning, in order to reassure the patient, but advise them of self care or alternative forms of treatment, what to do if their condition worsens (over a specific time frame), and what other symptoms, should they occur, might prove significant and justify a further request for advice or treatment.

You should also ensure that your staff are adequately trained to know how and when to draw a request to visit to your, or colleagues', attention. Moreover any telephone messages about such requests must specify the circumstances in which more urgent access, or telephoning 999, would be appropriate. Failure to do these things can expose yourself and the patient to an avoidable risk and lead to a serious complaint and/or litigation.

We will now attempt to differentiate between circumstances in which a GP visit may or may not be appropriate.

Circumstances in which a GP visit *is recommended*

a) *The terminally ill*

b) *The truly bed bound patient* (for whom travel to your premises by car would cause a deterioration in their medical condition, or unacceptable discomfort).

Circumstances in which a GP visit *may be advisable*

a) *Children under 5*

While many childhood ailments prove to be self limiting and not serious, requests from anxious parents, of under 5s especially, constitute a large proportion of all requests to visit. In most cases parents can be persuaded to bring the child to the surgery if it will result in them being seen immediately rather than having to wait for a visit, and travelling a few miles by car or taxi is unlikely to have a detrimental effect on the child's condition. However a failure to visit in a case where the parents are anxious, and the anxiety proves justified, is certain to lead to a complaint. Locally, the out of hours services often err on the side of caution with young children, and as they are sometimes able to offer patients transport, arrange to see sick children at the out of hours centre. If you feel the child should be seen, but the parents cannot easily bring the child to the practice, it may be appropriate to agree to visit (see Appendix - extract from NICE guidelines on escalation of care).

b) *Mentally ill patients*

When a request to visit a patient exhibiting signs of mental distress is received, it is usually better for such patients to be seen at home, where any risk to themselves or others can be minimised, where there will be fewer distractions, and the patient may be examined in a familiar and comparatively safe environment. The GP can then make a decision about the patient's state of mind, and what would be in their best interests to do at that point. (A brieflet on the responsibilities of GPs to respond to requests from approved healthcare professionals to assess patients under the Mental Health Act is available separately).

Circumstances in which a GP visit *is not usually required*

a) *Life threatening conditions*

Where heart attack, severe crushing chest pain, severe shortness of breath, or severe haemorrhage are involved the sensible approach is to call for an ambulance. Sometimes the GP may be able to visit immediately to help prepare the patient for travel by ambulance, but this is only likely to be possible where the GP has finished surgery and is on-call. GPs cannot be expected to be available speedily when they are already attending to booked patients.

b) *Minor self limiting conditions for which self care would be more appropriate.*

These include: common symptoms of childhood, i.e. fever, cold, cough, earache, headache, diarrhoea/vomiting, and most case of abdominal pain. Patients with these conditions are usually well enough to travel to the surgery should it be necessary. It is not harmful to take a child with fever outside (but see above, and in the Appendix, the guidance on treating children under 5).

c) *Chronic conditions*

Many of these including asthma, diabetes, COPD etc will be best treated at booked surgery clinic sessions, where appropriate examination and testing equipment is on hand.

Disclaimer: *This brieflet is intended as guidance only. The final decision to visit or not is dependent on the GP's clinical judgement and the patient's situation, needs and wishes.*

References

These guidelines have been put together and approved by Nottinghamshire LMC Ltd and should be read in conjunction with other advice listed in the references that follow:

1. GMC. Good Medical Practice. (November 2006).
   Available from: www.gmc-uk.org/static/documents/content/GMC_GMP_0911.pdf

2. Department of Health. The Primary Medical Services (Directed Enhanced Services) (England) 2010. (March 2010). Available from: www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Directionsfromthesecretaryofstate/DH_113692

3. NICE Guidelines. CG84 Diarrhoea and vomiting in children under 5. (April 2009).
   Available from: http://guidance.nice.org.uk/CG84/

4. NICE Guidelines. CG47 Feverish illness in children. (May 2007).
   Available from: http://guidance.nice.org.uk/CG47

Appendix 1 – Extract from NICE guidelines on diarrhoea and vomiting in children under 5

Chapter 9. Escalation of care

During remote assessment:

- Arrange emergency transfer to secondary care for children with symptoms suggesting shock (see Table 4.6 overleaf)
- Refer for face-to-face assessment children:
  - With symptoms suggesting an alternative serious diagnosis or
  - At high risk of dehydration, taking into account recognised risk factors or
  - With symptoms suggesting clinical dehydration or
  - Whose social circumstances make remote assessment unreliable
- Provide a 'safety net' for children who do not require referral. The safety net should include information for parents and carers on how to:
  - Recognise developing red flag symptoms (see Table 4.6 overleaf) and
  - Get immediate help from an appropriate healthcare professional if red flag symptoms develop.

During face-to-face assessment:

- Arrange emergency transfer to secondary care for children with symptoms or signs suggesting shock (see Table 4.6 overleaf)
- Consider repeat face-to-face assessment or referral to secondary care for children:
  - With symptoms and signs suggesting alternative serious diagnosis
  - With red flag symptoms and/or signs of dehydration (see Table 4.6 overleaf)
  - Whose social circumstances require continued involvement of healthcare professionals
- Provide a safety net for children who will be managed at home. The safety net should include:
  - Information for parents and carers on how to recognise developing red flag symptoms (see Table 4.6 overleaf) and
  - Information on how to get immediate help from an appropriate healthcare professional if red flag symptoms develop
  - Arrangements for follow-up at a specified time and place, if necessary.

Table 4.6 Symptoms and signs of clinical dehydration and shock

Interpret symptoms and signs taking risk factors for dehydration into account. Within the category of 'clinical dehydration' there is a spectrum of severity indicated by increasingly numerous and more pronounced symptoms and signs. For clinical shock, one or more of the symptoms and/or signs listed would be expected to be present. Dashes (–) indicate that these clinical features do not specifically indicate shock. Symptoms and signs with red flags (⚑) may help to identify children at increased risk of progression to shock. If in doubt, manage as if there are symptoms and/or signs with red flags.

	Increasing severity of dehydration →		
	No clinically detectable dehydration	**Clinical dehydration**	**Clinical shock**
Symptoms (remote and face-to-face assessments)	Appears well	⚑ Appears to be unwell or deteriorating	–
	Alert and responsive	⚑ Altered responsiveness (for example, irritable, lethargic)	Decreased level of consciousness
	Normal urine output	Decreased urine output	–
	Skin colour unchanged	Skin colour unchanged	Pale or mottled skin
	Warm extremities	Warm extremities	Cold extremities
Signs (face-to-face assessments)	Alert and responsive	⚑ Altered responsiveness (for example, irritable, lethargic)	Decreased level of consciousness
	Skin colour unchanged	Skin colour unchanged	Pale or mottled skin
	Warm extremities	Warm extremities	Cold extremities
	Eyes not sunken	⚑ Sunken eyes	–
	Moist mucous membranes (except after a drink)	Dry mucous membranes (except for 'mouth breather')	–
	Normal heart rate	⚑ Tachycardia	Tachycardia
	Normal breathing pattern	⚑ Tachypnoea	Tachypnoea
	Normal peripheral pulses	Normal peripheral pulses	Weak peripheral pulses
	Normal capillary refill time	Normal capillary refill time	Prolonged capillary refill time
	Normal skin turgor	⚑ Reduced skin turgor	–
	Normal blood pressure	Normal blood pressure	Hypotension (decompensated shock)

NICE Guidelines. CG84 Diarrhoea and vomiting in children under 5 (April 2009). Available from: http://guidance.nice.org.uk/CG84.

Appendix 2 – Extract from NICE guidelines on feverish illness in children

2.1 Key priorities for implementation (key recommendations)

Detection of fever

In children aged 4 weeks to 5 years, healthcare professionals should measure body temperature by one of the following methods:

- electronic thermometer in the axilla
- chemical dot thermometer in the axilla
- infrared tympanic thermometer (3.2.2)

Reported parental perception of a fever should be considered valid and taken seriously by health¬care professionals. (3.3)

Clinical assessment of the child with fever

Children with feverish illness should be assessed for the presence or absence of symptoms and signs that can be used to predict the risk of serious illness using the traffic light system (Table 4.1). (4.4)

Healthcare professionals should measure and record temperature, heart rate, respiratory rate and capillary refill time as part of the routine assessment of a child with fever. (4.5.2)

Management by remote assessment

Children with any 'red' features but who are not considered to have an immediately life-threat¬ening illness should be urgently assessed by a healthcare professional in a face-to-face setting within 2 hours. (5.3)

Management by the non-paediatric practitioner

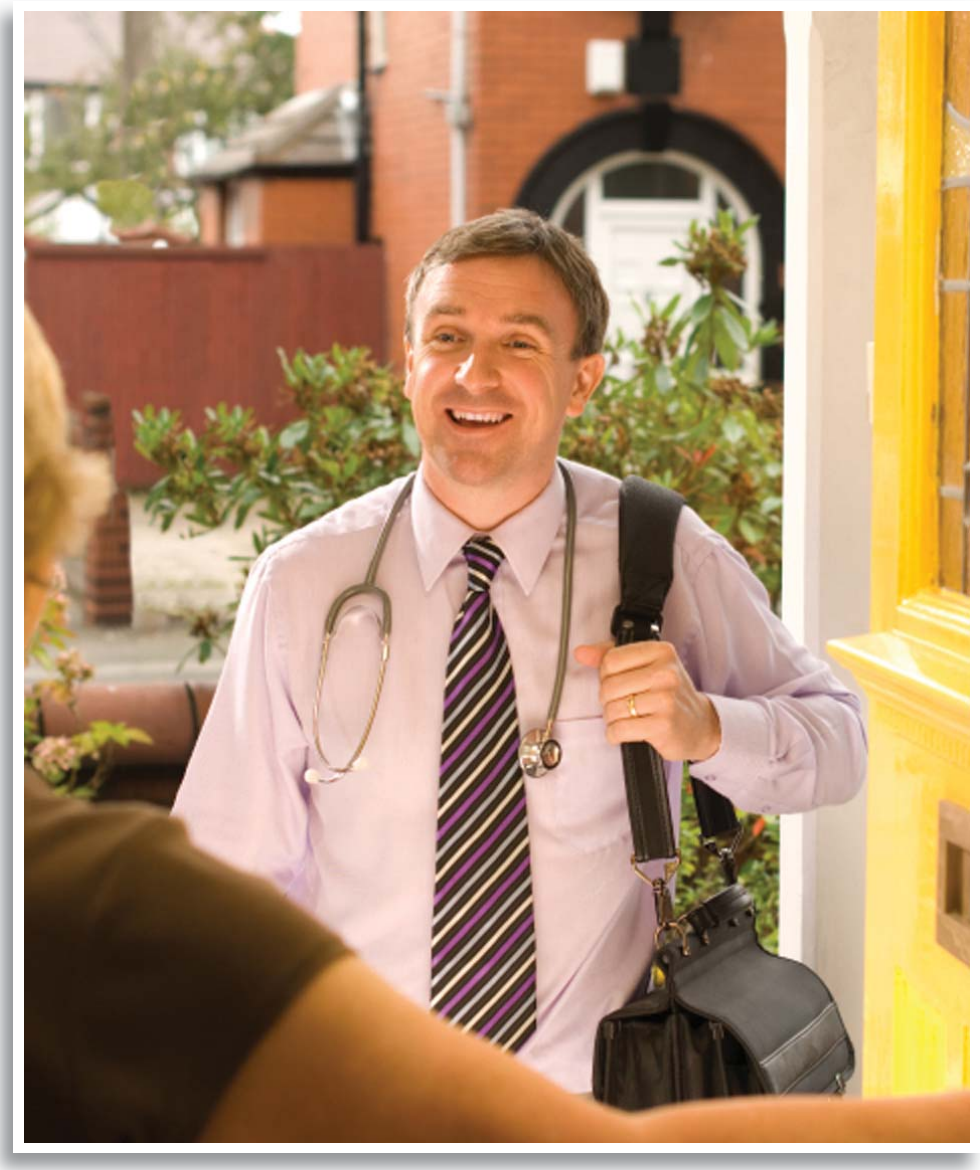
If any 'amber' features are present and no diagnosis has been reached, healthcare professionals should provide parents or carers with a 'safety net' or refer to specialist paediatric care for further assessment. The safety net should be one or more of the following:

- providing the parent or carer with verbal and/or written information on warning symptoms and how further health care can be accessed (see Chapter 9)
- arranging further follow-up at a specified time and place
- liaising with other healthcare professionals, including out-of-hours providers, to ensure direct access for the child if further assessment is required. (6.3)

Oral antibiotics should not be prescribed to children with fever without apparent source. (6.5.1)

Table 4.1 Traffic light system for identifying risk of serious illness.

Children with fever and any of the symptoms or signs in the 'red' column should be recognised as being at high risk. Similarly, children with fever and any of the symptoms or signs in the 'amber' column and none in the 'red' column should be recognised as being at intermediate risk. Children with symptoms and signs in the 'green' column and none in the 'amber' or 'red' columns are at low risk. The management of children with fever should be directed by the level of risk. (NICE Guidelines. CG47 Feverish illness in children (May 2007).



	Green – low risk	Amber – intermediate risk	Red – high risk
Colour	• Normal colour of skin, lips and tongue	• Pallor reported by parent/carer	• Pale/mottled/ashen/blue
Activity	• Responds normally to social cues • Content/smiles • Stays awake or awakens quickly • Strong normal cry/not crying	• Not responding normally to social cues • Wakes only with prolonged stimulation • Decreased activity • No smile	• No response to social cues • Appears ill to a healthcare professional • Unable to rouse or if roused does not stay awake • Weak, high-pitched or continuous cry
Respiratory		• Nasal flaring • Tachypnoea: RR > 50 breaths/minute age 6–12 months RR > 40 breaths /minute age > 12 months • Oxygen saturation ≤ 95% in air • Crackles	• Grunting • Tachypnoea: RR > 60 breaths/minute • Moderate or severe chest indrawing
Hydration	• Normal skin and eyes • Moist mucous membranes	• Dry mucous membrane • Poor feeding in infants • CRT ≥ 3 seconds • Reduced urine output	• Reduced skin turgor
Other	• **None** of the amber or red symptoms or signs	• Fever for ≥ 5 days	• Age 0–3 months, temperature ≥ 38°C • Age 3–6 months, temperature ≥ 39°C
		• Swelling of a limb or joint • Non-weight bearing/not using an extremity	• Non-blanching rash • Bulging fontanelle • Neck stiffness • Status epilepticus • Focal neurological signs • Focal seizures
		• A new lump > 2 cm	• Bile-stained vomiting

CRT, capillary refill time; RR, respiratory rate.

Table 4.4 Summary table for symptoms and signs suggestive of specific diseases

Diagnosis to be considered	Symptoms and signs in conjunction with fever
Meningococcal disease	Non-blanching rash, particularly with one or more of the following: • an ill-looking child • lesions larger than 2 mm in diameter (purpura) • a capillary refill time of ≥ 3 seconds • neck stiffness
Meningitis	Neck stiffness Bulging fontanelle Decreased level of consciousness Convulsive status epilepticus
Herpes simplex encephalitis	Focal neurological signs Focal seizures Decreased level of consciousness
Pneumonia	Tachypnoea (RR > 60 breaths per minute age 0–5 months, RR > 50 breaths per minute age 6–12 months; RR > 40 breaths per minute age > 12 months) Crackles Nasal flaring Chest indrawing Cyanosis Oxygen saturation ≤ 95%
Urinary tract infection	Vomiting Poor feeding Lethargy Irritability Abdominal pain or tenderness Urinary frequency or dysuria Offensive urine or haematuria
Septic arthritis	Swelling of a limb or joint Not using an extremity Non-weight bearing
Kawasaki disease	Fever for more than 5 days and at least four of the following: • bilateral conjunctival injection • change in mucous membranes • change in the extremities • polymorphous rash • cervical lymphadenopathy

NICE Guidelines. CG47 Feverish illness in children (May 2007). Available from: http://guidance.nice.org.uk/CG47

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