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# Safety-Netting: A Useful Clinical Tool

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The consultation is the basic activity in clinical practice. It is central to the art of medicine. Consultation models help to add a structure to the doctor-patient interaction. They all have the same basic components, an information input, information processing, and a results output.

The term safety-netting was coined in 1987 by Roger Neighbour, a Watford GP[1]. It is likely that it has always been practised but had not been formally recognised. It is an in-consultation tool for managing clinical uncertainty. It is particularly suited to general practice, hospital EDs and other areas where there is high volume and low acuity. It is about providing patients with information on what to expect in the immediate period after the consultation, and what to do if their condition does not improve. It is designed to help them identify when to seek further medical help. On the one hand it helps patients to know when to avoid seeking unnecessary follow-up consultations. On the other hand it points out the symptoms and signs that should prompt a patient to request another review. Safety netting explains to the patient the expected duration of their symptoms. Patients find this type of information very reassuring. It is suggested that the traffic-light framework should be used to give a structure to the medical advice that is being given. Green flags to continue with self-care at home, amber flag for a primary care review, and a red flag for an urgent review at the hospital ED. The advice must be precise about what type of service the patient needs to contact if there are new concerns.

Safety-netting is a recognition that the practice of clinical medicine is to some extent an imprecise science. It makes provision for an unexpected turn of medical events. Contingency plans can be built around these possibilities. It offers the patient an opportunity to discuss, understand, and agree with the plan related to their care.

Medico-legally, safety netting is often regarded as an expected standard of care. It is particularly important when patients are being discharged from the emergency department without a definite diagnosis. The NICE guideline on safety-netting states that the advice should set out the following, the existence of uncertainty, what exactly to look out for, how exactly to seek further help, and what to accept about the time course[2]. The most frequently debated item is around the time frame strategy as the recovery period depends on a wide range of factors. The background reservation is that serious illness can superimpose itself on what is usually a self-limiting condition.

The outcome metric used to assess safety-netting is the number of ED revisits. In paediatrics the number of revisits is highest in young children, particularly those under 12 months of age.

When correctly implemented it can mitigate the clinical risk if the patient's condition deteriorates unexpectedly. Safety-netting can fail in three circumstances. Firstly, it was never given. Second, it was poorly delivered, and the patient's understanding was not verified. Third, the information and advice given was insufficient[3]. The content of the discussion with the patient must not be complex. It should contain only the necessary amount of information, and jargon needs to be avoided. The delivery speed must not be fast. The tone must be measured, reassuring and open. Where necessary get an interpreter for patients whose first language is not English.

Safety-netting was just one of the components of Neighbour's five point consultation model. The other four items were: connecting, summarising, handing over, and housekeeping. The connecting item is about establishing a good working relationship with the patient. The summarising item is the ability to reiterate to the patient the main points raised during the consultation and the likely diagnosis. Handing over is concerned with returning to the patient control and responsibility for aspects of their healthcare where appropriate. Housekeeping relates to the doctor taking care of themselves, particularly avoiding fatigue, stress, and lack of concentration.

There is a lot included in the model to recommend. It is easy to remember. The safety-netting point is an important safety measure. Some commentators have suggested that it is a bit doctor centred at times.

There are other consultation models[4] including the Calgary Cambridge Model, 1996. Similar to Neighbour's model it emphasises the importance of safety netting. It consists of initiating the session, gathering information, physical examination, explanation, planning, and closing the session. This model has more of an emphasis on the clinical evaluation of the patient. It identifies the skills and behaviours required in each of the steps. It combines each of its components with the available research evidence on the skills that aid doctor-patient communication. Across the Model there are 71 micro-skills made available.

Interruptions during the medical consultation are considered to have an adverse effect on the doctor-patient relationship. The interruption rate in general practice has been reported to be 10% with over 50% of them being due to phone calls[5]. It creates a dilemma for doctors. The avoidance of interruptions must be balanced against the importance that patients place on direct phone access to their doctor. It was reassuring that most patients were not upset or distressed by the interruption. However, interruptions need to be avoided as much as possible.

Consultation models prevent the interaction between the patient and the doctor from becoming unfocussed and heading off in unhelpful directions. They provide a better understanding of the patient's perspective. They encourage doctors to be more thorough and to practice more safely. They provide the doctor with a framework on which to build their own individual approach and style. They are a reminder to incorporate the patient's ideas, concerns, and expectations.

Over the last few decades safety-netting has become accepted by many as a useful and effective addition to the medical consultation.

**References:**


1. Edwards PJ, Silverston P, Sprackman J, Roland D. Safety-netting in the consultation. BMJ 2022;378:e069094 July 25.
2. De Vos-Kerkhof E, Geurts DHF, Wiggers M, Moll HA, Oostenbrink R. Tools for safety-netting in common paediatric illnesses: a systematic review in emergency care. Arch Dis Child 2016;101:131-139
3. Gray SJ, Wacogne ID, Roland D. Fifteen minute consultation: safety-netting effectively. Arch Dis Child 2018;Nov 14 – 315991.
4. Mehay R, Beaumont R, Draper J, Lamb I, Moulton L, Kenny D. Revisiting models of the consultation. In: The Essential Handbook for GP Training & Education Ed. Ramesh Mehay. www.essentialgptrainingbook.com
5. Dearden A, Smithers M, Thapar A. Interruptions during general practice consultations – the patient's view. Family Practice 1996;13:166-169.