SUPPLEMENTARY BRIEF FOR NURSING EXPERT

RAYCHEL FERGUSON

Introduction

1.1 The Inquiry has received and considered your report dated 28 November 2011.

1.2 Having considered your report the Inquiry considers that there are a number of issues which require further consideration or clarification.

1.3 Therefore, you are asked to address the questions set out below and to answer them by providing a 'compendium report'.

1.4 As discussed during the teleconference which took place between you and members of the Inquiry's legal team on the 11 January 2012, your compendium report shall also incorporate the following additional sections:

- A description of relevant principles of nursing theory and practice linked to the nursing issues which arise in this case.

- A description of the key events in the nursing care and treatment of Raychel Ferguson based on your interpretation of the material with which you have been briefed. This section shall include an analysis of the standard of nursing care and administration provided in Raychel's case and it will highlight where, in your opinion, there is evidence of poor nursing practice. Finally, in this section of your report you will indicate what should have occurred in order to comply with principles of good nursing practice.

Questions Arising out of Section 4.2 of Your Report

2.1 Of, "It is difficult to determine the frequency with which Raychel vomited as there are differing views between Mrs. Ferguson and the information contained in the records." (page 9)

According to his statement to the Inquiry, when Dr. Devlin saw Raychel she was vomiting (WS-026), yet this episode of vomiting is not recorded in any of the notes or records made available to the Inquiry.

Apart from the views of Mrs. Ferguson to whom you have referred, and Mr. Ferguson (095-005-017), the statements of others who visited Raychel at (095-005-020), (095-007-022&023) and (095-009-028) contradict the views of Sister Millar and her nursing staff about Raychel's condition during 8 June 2001.

(i) **To what standard of record keeping were the nurses required to adhere and what is the source of that standard?**

(ii) **What does the failure to record the vomiting referred to by Dr. Devlin (and by others) indicate about the standard of record keeping?**

(iii) **What are the possible implications of failing to make accurate records of vomiting?**

(iv) **What conclusions if any do you draw from the contradictory views which have been expressed about the severity of Raychel's vomiting and her overall condition?**

2.2 Of, "It is also unclear when the first anti-emetic of ondansetron (Zofran) was given as Dr. Devlin did not record the time and there is no entry in the care plan to indicate it had been prescribed and whether or not it was successful. Sister Miller recalls it was given at 6.30pm on 8th July (sic). Raychel had, therefore, been experiencing untreated discomfort for approximately 10 hours. I have concluded there was a delay in seeking medical advice on managing the PONV" (page 9)

(i) **What record, if any, should members of the nursing team have made in relation to the prescription of the first anti-emetic?**

(ii) **Did this delay in seeking medical advice fall below acceptable standards? If so what was the acceptable period within which such medical advice should have been sought?**

(iii) **What were the consequences of this delay for Raychel?**

(iv) **What steps should the nursing team have taken in order to obtain medical advice?**

(v) **At what time on the 8 June 2001 should they have taken steps to obtain medical advice?**

2.3 Of, "A naso-gastric tube is indicated where the surgery requires the stomach to be drained of bile and secretions. It is not usual for a naso-gastric tube to be used following a straightforward appendicectomy." (page 9)

(i) Is it likely that the use of a naso-gastric tube would have alleviated the symptoms of nausea and vomiting?

(ii) Is it likely that the use of a naso-gastric tube would have enabled accurate recording of gastric losses?

(iii) Was the use of a naso-gastric tube indicated in Raychel's case? What is the established guidance on the use of naso-gastric tube in paediatric surgery?

Questions Arising out Section 4.3 of Your Report

3.1 Of, "Using the above formulas [ie. "Child over 20kg - 1500mls plus 20mls/kg over 20kg"] the Solution 18 at 80mls hourly was excessive even before a post-operative fluid restriction." (page 9)

(i) How much of a restriction would have been expected and why?

3.2 Of, "I do not believe it would have been common practice at the time for a nurse to recalculate intravenous therapy. However, I think an experienced nurse should have noticed that the volume was excessive." (page 9)

(i) What steps would an experienced nurse have been expected to take in order to check that the volume of IV fluids being administered was not excessive?

(ii) Having identified the volume as being excessive, what then should an experienced nurse have done?

3.3 Of, "I consider a prescription for intravenous therapy should have been written before Raychel returned to the ward." (page 10)

(i) What was the usual practice at the time (June 2001)?

(ii) Who should have been responsible for writing the prescription?

3.4 Of, "The recording of oral intake is, in my opinion, important as when oral intake has increased sufficiently, the intravenous

infusion needs to be decreased in order to maintain an appropriate total fluid intake." (page 11)

(i) Should an evaluation of fluid input have appeared in the care plan?

(ii) If so, what steps should have been taken to evaluate and record fluid input?

3.5 Of, "Although accuracy may be difficult and in straightforward situations, unnecessary, an indication of output can be achieved by asking the child or parent at regular intervals. Where accuracy is needed the child can be asked to place a receptacle in the toilet to facilitate measurement." (page 11)

(i) Should the passing of urine have been measured in this instance?

(ii) If so, please explain why?

3.6 Of, "Descriptions and volume in relation to vomit are always subjective as there is no effective way to catch and measure sudden vomit." (page 11)

(i) Could Raychel have been provided with a vomit bowl as a means to catch the vomit and so provide a basis for measurement?

(ii) If so, what might be a reasonable basis for not doing so and is there any evidence that you can see of that in Raychel's case?

3.7 Of, "I believe the failure to note oral intake and urine output were omissions in nursing care. However, Dr. Butler, Dr. Devlin and Dr. Curran all wrote prescriptions and, therefore, had an opportunity to assess Raychel." (page 11)

(i) Taking each doctor separately, did they each have a responsibility to assess Raychel if they prescribed for her?

(ii) Please explain the reasons for your opinion in respect of each doctor?

<u>Questions Arising out Section 4.4 of Your Report</u>

4.1 Of, "Raychel's vital signs were recorded on an untitled chart and on a 4 hourly T.P.R. chart. Although the care plan required 15 minute recordings for 2 hour period I consider these was not needed (sic)." (page 12)

(i) What is the purpose of the care plan and how and on what basis is it revised?

(ii) If periodic recordings are required by the care plan, then should that plan have been adhered to? What are the circumstances in which it is acceptable not to follow the requirements of a care plan? How should any such failure or departure be addressed in the records?

Questions Arising out Section 4.5 of Your Report

5.1 Of, "The evaluation entries do not give a clear picture of Raychel's condition nor her mother's concerns." (page 14)

(i) What should the evaluation entries have included in order to provide a clear picture of Raychel's condition?

(ii) In what particular respects do the entries fail to provide a clear picture of Raychel's condition?

(iii) What should the evaluation entries have included in order to reflect Raychel's mother's concerns?

(iv) What is the significance of any omission to accurately record a patient's condition or a parent's concerns?

5.2 Of, "Throughout the care plan Raychel is referred to as "the child". It is unusual in my experience for the child's name not to be used in order to personalise the plan of care." (page 14)

(i) How do you interpret this lack of personalisation and what is its significance?

5.3 Of, "Although S/N Rice was regarded as a junior staff member, the care of a child following appendicectomy is, in my opinion, within the competence of any registered nurse. However, experience may require them to be supported and this was appropriately undertaken by Sister Miller."

(i) **Please clarify whether your opinion is that Sister Miller provided appropriate support to S/N Rice?**

(ii) **If so, how did Sister Miller provide this support?**

(iii) **Was the support provided by Sister Miller to S/N Rice adequate in the circumstances?**

(iv) **Should Sister Miller have assessed Raychel herself?**

5.4 Of, "It also appears that post-operatively no single doctor saw her more than once." (page 14)

(i) **Would it be normal for no single doctor to see a surgical patient more than once?**

(ii) **What were the implications of this?**

5.5 Of, "...I believe the nurses were unsure of which doctor to call and who had responsibility for Raychel's care." (page 14)

(i) **What is the basis for your belief that the nurses were unsure which doctor to call and were unsure of which doctor had responsibility for Raychel's care?**

(ii) **What if any protocols existed at the time (June 2001) to govern the establishment and communication of the 'chain of command'? What system should have been in place to ensure that nurses were aware of which doctor to contact and who had responsibility for Raychel's care?**

(iii) **What were the implications of any uncertainty on the part of the nurses in terms of which doctor to call or with regard to who had responsibility for Raychel's care?**

<u>Questions Arising out Section 5 of Your Report</u>

6.1 Of, "Two actions documented in the care plan were not implemented: observe/record urinary output (020-027-063); encourage oral fluids, record (020-027-059)." (page 17/18)

(i) **Arising out of what is recorded at (020-027-063), have you any comment to make in relation to the listed frequency of observations?**

(ii) **Should the 'planned' observations have been adhered to?**

(iii) **If there was no requirement to adhere to the planned observations, should a note have been made in the evaluation with regard to the reasons for reducing the frequency of observations?**

6.2 Of, "In my opinion the nurses should have been aware that vomiting can lead to dehydration and electrolyte imbalance and that fluid lost must be replaced." (page 18)

(i) **On what basis do you say the nurses should have been aware of this?**

(ii) **Did Sister Miller have a role in raising this awareness?**

(iii) **If so, what steps should she have taken when Raychel was on the ward?**

(iv) **What steps should any other member of the nursing team have taken to address the issue of replacement fluids?**

6.3 Of, "By 10.30 I think a doctor should have been advised of the vomiting. If the vomiting that occurred in the afternoon had been recorded this may have acted as a further prompt to seek an anti-emetic and give an opportunity for medical assessment. There were no significant changes in vital sign recordings between 9am and 5pm and it likely that Raychel's appearance was unchanged." (page 18)

(i) **Why have you identified 10.30 as being the time that a doctor should have been advised of the vomiting?**

(ii) **In your opinion when did the vital signs fall outside the normal range for Raychel?**

6.4 Of, "I have concluded that it was common practice for patients to be cared for by Senior House Officers. It is my opinion that the Senior House Officer was responsible for seeking advice from a more senior doctor." (page 20)

(i) **Are there any circumstances in which a nurse might contact a more senior doctor? If so, in what circumstances might this occur?**

6.5 Of, "S/N Rice (McCauley) was caring for Raychel during the day shift. As a junior staff nurse she was being supervised by Sister

Miller. I think that S/N Rice or Sister Miller should have contacted a doctor..." (Page 21)

(i) At what time and in relation to what development or event should S/N Rice pr Sister Miller have contacted a doctor?

(ii) Should Sister Miller have made an assessment of Raychel at any point, and if so, when?

6.6 Of, "The brief synopsis of information given to Raychel's family, recorded in the care plan, appears appropriate for a child undergoing an appendicectomy."(Page 21)

(i) What information are you referring to in this context?

(ii) On what basis do you say that the information given to Raychel's family appears appropriate?

6.7 Of, "It is important for nurses to listen to parents. None of Mrs. Ferguson's concerns were recorded in the care plan." (Page 21)

(i) Is there any evidence of appropriate responses to parental concerns, regardless of whether those concerns were recorded in the care plan?

Conclusion

7.1 It is of fundamental importance that the Inquiry receives a clear reasoned opinion on the issues you have been asked to address. In particular, please ensure that you provide and clearly explain the basis for the views that you express.

7.2 Your assistance on the Inquiry's requirements should be provided in the form of a fully referenced Report. In particular, where your analysis or view is based on external materials (ie the published literature, protocols, guidelines)

7.3 You are invited to contact the Inquiry's Legal Team through the Inquiry's Secretary if any further clarification is required.