COMMENTS ON THE REPORT OF THE INQUIRY ADVISERS RE RAYCHEL FERGUSON

The Inquiry's Expert Advisers have prepared a very thorough report about the care of Raychel Fergusson. I would agree with the interpretation and evaluation of the nursing care delivered, except where indicated below. My comments mainly relate to issues about documentation and the adequacy of the type of charts that were in use.

Section 9.g Medical and nursing documentation

The nursing notes are identified as not meeting the standard of record keeping as determined by the Nursing and Midwifery Council. The medical notes are described as 'non-existent'. Were there standards or local guidelines for documentation of medical notes?

There seemed to be several different places to document care which makes it more difficult for the treating team to evaluate care in the chronological order that it was given. It appears that the nursing care on the 8th June was written on the chart 'Paediatric Unit Altnagelvin Area Hospital' where the frequent observations were recorded, along with other comments. On the 7th and 9th June the 'Observation Sheet' was used. It may be helpful to clarify if this was usual practice and whether staff would know to review each of these documents. The entry written in the 'Episodic Care Plan' about pain control on the 9th June at 06:00 highlights why it is important to document care as close as possible to the timing of an event – these comments would have been written prior to Raychel's deterioration at 03:05.

I note the 4 hourly TPR chart has an area to summarise vomiting, amount of urine, stools etc. It is unusual to see information about the amount of urine and vomiting on a TPR chart. Was there an expectation for this section to be completed? If so, it may have helped alert clinicians about the extent of the vomiting.

Section 15 Prescription of postoperative fluids

There is no place for the prescriber to note the date and time of the fluid prescription on the 'Parenteral Nutrition Fluids Prescription Chart' - nor is the patient's name identifiable on the chart. An IV fluid order should be checked in a similar way to any medication order, which includes identifying the correct name of the patient and the unique record number, the prescription date and time, along with the other administration details of the intended fluid. Maybe, as noted in Susan Chapman's report, these details are found on the reverse side of the form. The patient's weight is not recorded on the 'Fluid Balance for IV Fluids' chart. Having the weight recorded on the chart helps clinicians to quickly check that the rate of fluid administration is appropriate for the weight of the child.

Section 19.iii and 4 Unaware of age-related variation in normal nursing observations

The reference ranges for normal heart rate (HR) and respiratory rate (RR) for a child of this age can be quite variable and some texts and clinical guidelines would not necessarily indicate that a HR of 101 beats per minute (bpm) was particularly elevated. For example, reference values commonly used at our hospital indicate HR ranging 70-110bpm for an 8 year old and 60-105bpm for a 10 year old (http://www.rch.org.au/clinicalguide/forms/resusCard.cfm).

Examining the trending of the values over time and interpreting any changes in relation to current clinical status and relevant interventions is an important aspect of nursing assessment. Raychel's anaesthetic record indicates a tachycardia of 130's that has been described as within normal limits (p.3 of the report). Although tachycardia may be expected under anaesthesia and during surgery, this HR was elevated. During her time in recovery her HR declined to 108 to 117, and early in her postoperative course on the ward her HR was noted as 100 (8th June, 01:55), which later stabilised around the mid 80's to 90s. There were other occasions where her HR increased to about 100 (05:00 and 09:00 on the 8th June), which stabilised around 90 during the afternoon, before increasing again to 101 at 21:15. It is not possible to know if the HR was sustained at 100 for any prolonged long period as from 09:00 on the 8th June her observations were recorded less frequently, at 4 hourly intervals. Considering Raychel's problem of frequent vomiting throughout the day, it is surprising that vital sign observations were not taken more regularly.

It is difficult to appreciate the trends in vital signs when there are two different charts in use. The 4 hourly TPR chart enabled the values to be graphed, which makes it easier to note the trends, albeit at less frequent intervals. However, the majority of her observations were recorded on a separate chart, and not graphed, so the variations in vital signs would be more difficult to discern.

Other

Error on page 17 – I think the date is meant to be 2001 rather than 2005