Witness Statement Ref. No. 026/2

NAME OF CHILD: RAYCHEL FERGUSON

Name: Mary Butler

Title: Dr.

Present position and institution:

General Practitioner, Maine Medical Practice Ahoghill

Previous position and institution: Paediatric Medical SHO, Altnagelvin Hospital
[As at the time of the child's death]

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since your Witness Statement dated 1st July 2005]

None

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death since your Witness Statement dated 1st July 2005]

Inquiry Statement 1st July 2005
PSNI Statement 13th April 2006

OFFICIAL USE:
List of previous statements, depositions and reports attached:

Ref:	Date:	
026/1	14.07.2005	Inquiry Witness Statement

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached

I. QUERIES IN RELATION TO YOUR MEDICAL QUALIFICATIONS, EXPERIENCE, TRAINING AND RESPONSIBILITIES

(1) Please provide the following information:

(a) Describe your work commitments as a Paediatric Medical SHO in the Altnagelvin Hospital from the date of your appointment in February 2001 to the 8th June 2001, stating the locations in which you worked and the periods of time in each department/location.

General care of the children in ward 6, infant unit, neonatal intensive care, post natal ward, labour ward and day care unit.

Admitting paediatric patients to ward 6 and the infant unit, neonates to the neonatal unit and documenting the admission. Carrying out blood tests were appropriate. Inserting intravenous cannulas and prescribing.

Attending out patient clinics and ward rounds and often writing the ward round notes. Checking and recording blood test results when available.

Carrying out postnatal baby checks and attending labour ward when required, reviewing patients, taking bloods or inserting intravenous lines in Day Case Unit.

Completing discharge letters.

Part of the on call duty rota system.

Attending perinatal meetings and any teaching sessions organised.

I am unable to recall specifically the locations I worked in and for how long. I can only remember attending perhaps one or two out patient clinics in the six-month period.

I have referred to the job description for Paediatric Medicine SHO 2/99 and Induction to Medical Paediatrics February 2001 -enclosed.

(b) Describe your duties as a Paediatric Medical SHO at Altnagelvin Hospital on the 8th June 2001.

I am unable to remember what my specific duties were on 8th June 2001, at this far remove.

(c) How much experience did you have of working with post-surgical patients on a paediatric ward by the 8th June 2001?

I am unable to recall how much experience I had dealing with post surgical patients on a paediatric ward prior to 8th June 2001. Prior to February 2001 I hadn't worked with post surgical paediatric patients.

(2) At the time of your appointment to Altnagelvin Area Hospital Scheme in August 2000 were you provided with training or induction and if so,

(a) Describe the training or induction which you received.

I cannot recall specifically induction and training but at beginning of August 1999, which is when I started work in Altnagelvin Area Hospital Scheme, I think the first day we had an induction course and cardio pulmonary resuscitation training either that day or shortly thereafter.

(b) State the date or the approximate date when you received any training or induction.

Early August 1999 approximately.

(c) Identify the person(s) who delivered this training or induction.

Ursula McCollum was the CPR trainer; apart from that I am unable to remember any other speakers- timetable enclosed.

(d) Indicate if you received any documentation at this training or induction.

I am unable to recall if I received any documentation at this induction, though I do have some CPR handouts I suspect was from that time.

(3) Did you receive any additional training or induction when you went into Paediatrics in February 2001 and if so,

(a) Describe the training or induction which you received.

From memory, we were given an induction booklet for medical paediatrics, shown the various wards we would be based on, shown how to do a postnatal baby check, the different blood containers to use in paediatric patients and how to perform near patient blood gases for the neonatal unit infants.

I attended a neonatal resuscitation-training day in Royal Maternity Unit also

(b) State the date or the approximate date when you received any training or induction.

The initial induction was the first day we started work in paediatrics, which would have been approximately start of February 2001.

The neonatal resuscitation Training Day was 26/3/01- booklet cover/flyer enclosed.

(c) Identify the person(s) who delivered this training or induction.

The induction was by one of the male senior registrars. I an unable to remember his name.

(d) Indicate if you received any documentation at this training or induction.

I received an induction booklet for medical paediatrics- enclosed.

(4) Provide full details of any advice, training or instruction which was provided to you at Altnagelvin Hospital in order to inform you about any of the following issues:

- Hyponatraemia
- Post Operative Fluid Management
- Record keeping regarding fluid management

And address the following -

(a) Who provided this advice, training or instruction to you?

I do not remember having any advice, training or instruction with regard to hyponatraemia, post operative fluid management or record keeping regarding fluid management. I am aware I knew that urea and electrolytes needed checked daily on paediatric patients on ongoing intravenous fluids and recorded and acted on if necessary, when results were available.

(b) When was it provided?

I cannot remember at this far remove.

(c) What form did it take?

I cannot remember specifically but from memory a lot of it was learning on the ward rounds with the consultants and registrars.

(d) What information were you given?

I cannot remember at this far remove.

(e) In particular what information were you given in relation to the allocation of responsibility for prescribing intravenous fluids for post-operative children?

I do not recall any specific information I was given in relation to allocation of responsibility for prescribing intravenous fluids for post-operative children.

II. QUERIES ARISING OUT OF YOUR INITIAL STATEMENT TO THE INQUIRY (WS-026/1)

(5) *"I prescribed solution 18, 1 litre to be infused at a rate of 80ml per hour and filled in "1000" under amount, "soln 18" under the type of fluid "80" under the rate per hour and signed the chart 020-019-038."*

(a) Is the calculation set out on the top of the chart at 020-019-038 in your handwiriting?

No.

(b) Did you perform a calculation before prescribing 80ml/hr of Solution 18?

No.

(c) What factors did you take into account when you prescribed at a rate of 80ml/hr?

That Raychel had her appendix removed during the night and needed further maintenance fluids. I would have expected through the day of the 8th June 2001 the intravenous fluids would have been turned down and stopped as Raychel started to take sips and drink.

(d) Why did you prescribe at a rate of 80ml/hr?

I prescribed at a rate of 80ml/hr as I was informed that was the rate Raychels fluids were running at since her surgery. I do not recall if I was told that by the staff nurse or if I seen it on the fluid prescrition sheet. The fact that Raychel had been through surgery, some hours previously I had assumed her weight was used to calculate her intravenous fluids rate and anaesthetic doses.

(e) Was 80ml/hr an appropriate rate to prescribe in the circumstances of Raychel's case and given her weight etc?

Given Raychel's weight was 25kg ,80ml/hr as a rate was running too high.

(f) Why did you prescribe Solution 18?

Because solution 18 was used as maintenance fluids in paediatric patients at that time.

(g) In your experience of working in paediatrics in Altnagelvin Hospital, in what circumstances were you asked by nursing staff to prescribe for a surgical patient?

From memory, regularly I would have been asked to prescribe intravenous fluids or analgesia for surgical patients as the surgical teams would have been in theatre, accident and emergancy or out-patient clinics.

(h) Did you give any consideration to contacting a member of the surgical team before prescribing for Raychel (who was a surgical patient)? If not, please explain why you didn't?

I do not remember specifically in Raychels case, but often the information I was given in this situation was that this was the plan from the ward round but had not been prescribed during the round as it may have been forgotten or the team may have been called away.

I didn't contact the surgical team, as this would have been a regular request and I didn't recall any specific concerns about Raychel, otherwise I would have suggested that the staff nurse contacted the surgical team initially.

(i) Did you report your intervention in Raychel's case to any member of the surgical team?

Not that I remember.

(j) Did you provide nursing staff with any advice or direction with regard to the ongoing care of Raychel?

Again I cannot remember specifically in Raychels case, but generally in a post operative surgical patient as they would start to take sips and drink, the intravenous fluids would be turned down and stopped over the next few hours, unless there were any concerns where the patient would need to be reviewed.

(6) *"One of the inquiries I probably would have made is to ascertain how long it was after surgery as I would have been concerned if the child had been on fluids for more than 24 hours after surgery. I would also have inquired as to the general condition of the child. I cannot recollect the nursing staff expressing any concerns about the child. If they had done so I would have examined the child."*

(a) Why would you have been concerned if the child had been on fluids for more than 24 hours?

If Raychels had been on intravenous fluids for more than 24 hours, I would have been concerned as at that stage, I would have expected Raychel to be drinking and her intravenous fluids discontinued. If not, and Raychel remained on intravenous fluids, for 24hours or more, I would have suggested she was reviewed and also should have a urea and electrolyte blood sample taken before issuing a further intravenous fluid prescription.

(b) Insofar as you can recall did the nurse tell you about any of the following matters:

(i) The surgeon's plan for Raychl's fluid management;

I cannot remember.

(ii) That Raychel had passed urine post-operatively;

I cannot remember.

(iii) That Raychel had taken some sips of clear liquid by mouth.

I cannot remember.

(iv) That Raychel had vomited at 08.00 and 10.00?

I cannot remember.

(c) If you were advised of any of these matters, did it effect the fluid prescription which you issued?

I cannot remember specifically, but if there had been concerns about Raychels fluid management or vomiting and it was highlighted to me I would asked the staff nurse to bleep a member of the surgical team or would spoken to one of the paediatric registrars before issuing a further intravenous fluid prescription.

(d) If you weren't advised of these matters, please comment on whether it is likely that you would have taken any different steps before prescribing for Raychel, had you known about them at the time?

If there had been concerns about Raychels fluid management or vomiting I would have advised the staff nurse to contact the surgical team in the first instance rather than prescribing further intravenous fluids, so Raychel would have been reviewed, or I would have spoken to one of the paediatric registrars for advice.

(7) *"The policy at that time in Altnagelvin Area Hospital was that if paediatric patients needed fluids the fluids prescribed were solution 18."*

(a) How were you advised that the policy at the time was to use Solution 18?

I cannot rememeber who advised.

(b) What explanation, if any, were you given for this policy?

I do not remember any explanation being given for this policy, because it was so long ago.

(c) Did you have any concerns about that policy and the generality of its application?

At the time I didn't have any concerns about the generality of its application.

(d) What was your understanding of the application of the policy in cases where there was evidence of repeated vomiting post-surgery?

My understanding was that soluion 18 was used as maintenance fluids in paediatric patients. Also that post operative paedictirc patients would often vomit initially post operatively but as they started to take sips and drink the intravenous fluids were turned down and stopped. Also if the vomiting was prolonged or severe the patient would be reviewed.

III. INTERRACTION WITH NURSING STAFF AND SURGICAL STAFF

(8) In 2001, how many members of the paediatric team would have been based at or near ward 6 of Altnagelvin Hospital, and what were their grades?

From memory there was generally always two paediatric SHOs present on ward 6/infant unit though the daytime and if a ward round was taking place a registrar and usually a consultant also.

(9) In your experience of working as a paediatric medical SHO in Altnagelvin, clarify whether a member of the paediatric team would have been a constant presence on or near ward 6?

From memory there was generally always a paediatric SHO present on or near ward 6.

(10) If not,

(a) Explain how the paediatric team worked;

(b) Explain the circumstances in which they would come to be present on ward 6;

(c) Specify where they would be located if not in ward 6;

(d) Clarify how they could be contacted by nursing staff if not in ward 6?

(11) Insofar as you can recall, at what locations did you carry out your work within the Hospital on the 8th June 2001?

I cannot recall specifically where I carried out work on 8th June 2001

(12) Were you asked to see Raychel again after you had prescribed fluids for her?

No. If I had been asked to see Raychel, I would have spoken to a Registrar and documented this in Raychel's notes.

(13) Was there any practice or policy in operation in Altnagelvin in 2001 which would have prevented nursing staff from asking a member of the paediatric team,

(a) To advise in relation to a surgical patient;

Not that I recall

(b) To examine a surgical patient;

Not that I recall

(c) To prescribe for a surgical patient;

Not that I recall

(d) To carry out tests, such as to take bloods for electrolytes or to investigate for the cause of vomiting.

Not that I recall

(14) Was there any practice or policy in operation in Altnagelvin in 2001 which would have prevented surgical staff from asking a member of the paediatric team,

(a) To advise in relation to a surgical patient;

Not that I recall

(b) To examine a surgical patient.

Not that I recall

(c) To prescribe for a surgical patient;

Not that I recall

(d) To carry out investigations, such as to take bloods for electrolytes or to investigate for the cause of vomiting.

Not that I recall.

(15) In 2001 what was your experience, if any, of being asked by nursing staff or surgical staff,

(a) To advise in relation to a surgical patient;

From memory, for an opinion/ or to advise about a surgical patient, the request would have been made from the surgical team to the paediatric registrar.

(b) To examine a surgical patient.

From memory, for an opinion/or to advise or examine a surgical patient, the request would have been made from the surgical team to the paediatric registrar.

(c) To prescribe for a surgical patient;

Ongoing intravenous fluids or analgesia was often requested by paediatric SHOs on Ward 6

(d) To carry out investigations.

Investigations such as taking specific bloods that couldn't be obtained by the surgical team would be taken if requested, or intravenous lines sited also.

IV. QUERIES ON THE ISSUE OF FLUID MANAGEMENT

Please provide clarification and/or further information in respect of the following:

(16) In June 2001 who in Altnagelvin Hospital was responsible for organizing the structure and allocation of responsibilities for post-operative fluid management for paediatric cases?

Form memory post operative fluid management was prescribed either by the surgical team or paediatric SHOs on the ward

(17) In Altnagelvin Hospital in 2001, was there a policy or protocol (written or unwritten) for dealing with post-operative fluid management in children? If so please address the following:

(a) Was that policy or protocol brought to your attention?

I do not recall any policy or procedure for dealing with post operative fluid management in children

(b) If so, how was it brought to your attention?

I cannot recall.

(c) Did the policy/protocol identify who (in terms of the medical discipline - surgeon, anaesthetist or paediatrician) was responsible for prescribing intravenous fluids for children post-operatively?

I cannot recall specifically but often it would initially have been the anaesthetist or surgical team.

(d) What was your understanding of the prescribing responsibility for post-operative children?

Generally I would have thought it was the surgical team.

(18) Prior to 8th June 2001:

(a) State your knowledge and awareness of the cases of Lucy Crawford, Claire Roberts, or Adam Strain, and the issues arising from those cases.

Prior to the 8th June 2001 I had no knowledge of the cases of Lucy Crawford, Claire Roberts or Adam Strain or the issues arising from those cases.

(b) State the source(s) of your knowledge and awareness and when you acquired it.

N/A

(c) Describe how that knowledge and awareness affected your care and treatment of Raychel.

N/A

(19) Since 8th June 2001:

(a) State your knowledge and awareness of the cases of Lucy Crawford, Claire Roberts or Adam Strain, and the issues arising from these cases.

Since 8th June 2001, I became aware of the cases of Lucy Crawford, Claire Roberts, Adam Strain and Raychel Ferguson and the issues arising from these cases in 2005 when I was asked to provide a statement to the Inquiry team.

(b) State the source(s) of your knowledge and awareness and when you acquired it.

I started my GP registrar year in August 2001 and as I result have had no exposure to prescribing paediatric intravenous fluids since then. My knowledge and awareness came from being contacted by the Inquiry and reading the information mainly from the Inquiry website.

(c) Describe how that knowledge and awareness has affected your work.

Since August 2001 I have not been required to prescribe intravenous fluids for children, but I am acutely aware of hyponatreamia and fluid management in paediatric patients and its complications. As above.

(20) Prior to Raychel's death were you aware of the literature which highlighted the dangers posed by the administration of hypotonic fluids to children during the immediate post operative period? eg. Arieff AI, Ayus JC. British Medical Journal 1992: 304; 1218-1222. Hyponatraemia and death or permanent brain damage in healthy children, or Halberthal M, Halperin ML, Bohn D. British Medical Journal 2001: 322; 780-782. Lesson of the week: acute hyponatraemia in children admitted to hospital: retrospective analysis of factors contributing to its development and resolution.

No.

(21) Describe in detail the education and training you have received in fluid management (in particular hyponatraemia) and record keeping, to include any particular training relating to fluid management in children, and provide dates and names of the relevant institutions/bodies, by reference to the following:

(a) Undergraduate level.

(b) Postgraduate level.

(c) Hospital induction programmes.

(d) Continuous professional development.

I am unable to recall any specific education or treatment I received at any stage in fluid management in children and record keeping related to fluid management at any level or induction programme.

(22) In 2001, what did you understand were the possible dangers for a child who was experiencing prolonged vomiting after surgery and who was in receipt of hypotonic intravenous fluids?

In 2001 I was not aware of the danger of hyponatraemia in children having prolonged vomiting after surgery in receipt of hypotonic intravenous fluids.

(23) Prior to 8th June 2001, describe in detail your experience of dealing with children with hyponatraemia, including the:

(a) Estimated total number of such cases, together with the dates and where they took place.

None that I am aware of.

(b) Nature of your involvement. N/A

(c) Outcome for the children. N/A

(24) Since 8th June 2001, describe in detail your experience of dealing with children with hyponatraemia, including the:

(a) Estimated total number of such cases, together with the dates and where they took place.

None that I am aware of. As I have been a GP,I have little exposure to children with hyponatraemia, as I do not prescribe intravenous fluids.

(b) Nature of your involvement. N/A

(c) Outcome for the children. N/A

V GENERAL

Please address the following:

(25) The Inquiry has been provided with observation sheets in respect of Raychel for the 7th June (Ref: 020-016-031) and the 9th June 2001 (Ref: 020-016-032)? Do you know whether an observation sheet was completed for the 8th June 2001?

I don't remember if one was completed, or seeing an observation sheet for Raychel for 8th June 2001 but I would have thought one would have been completed.

If an observation sheet was completed for the 8th June 2001, please address the following matters:

(a) Do you know what has become of that document?

No.

(b) Did you make any entries in that document?

Not that I recall.

(c) If you did make entries in that document are you able to provide any indication of the content of those entries?

N/A

(26) After Raychel's death were you asked to take part in any process designed to learn lessons from the care and treatment which she received and your role in it, to include any issue about her fluid management? If so,

No. I finished my paediatric SHO attachment in Altnagelvin Hospital at the end of July /start of August 2001.

(a) Describe the process which you participated in. N/A

(b) Who conducted it? N/A

(c) When was it conducted? N/A

(d) What contribution did you make to it? N/A

(e) Were you advised of the conclusions that were reached, and if so, what were they? N/A

(f) Were you advised of any issues relating to your role in Raychel's care and treatment? N/A

(g) Describe any changes to fluid management practice that you were made aware of at Altnagelvin Hospital following Raychel's death. N/A

(27) Provide any further points and comments that you wish to make, together with any documents, in relation to:

(a) The care and treatment of Raychel in Altnagelvin Hospital between the 7th – 9th June 2001.

I am deeply sorry Raychel became unwell and subsequently died following her admission to Altnagelvin Area Hospital.

(b) Record keeping. See below

(c) Communications with Raychel's family about her condition, diagnosis, and care and treatment. As above.

(d) Working arrangements within the surgical team and support for junior doctors. As above.

(e) Lessons learned from Raychel's death and how that affected your practice at Altnagelvin or elsewhere. As above.

In my current employment, as a GP I do not prescribe intravenous fluids. I am certainly aware of the dangers of hyponatraemia-whatever the cause. I know that solution 18 is no longer used as maintenance fluids in Altnagelvin Area Hospital and has been replaced with 0.45%saline with 2.5%dextrose, and also that post operative children have electrolytes carried out 12hours post surgery and 24hourly thereafter.

(f) Current Protocols and procedures.

I have read the protocol for prescribing intravenous fluids in post operative children issued from 9/5/2 in Altnagelvin. Ref No.021-048-104 and 021-048-105.

(g) Any other relevant matter.

I have endeavoured to answer these questions to the best of my knowledge. The first time I became aware of the situation regarding Raychel was in 2005 when I was asked to make a statement for the Inquiry team. Even at that stage, I had very little recollection of what I was doing while at work 4 yrs earlier or details about the induction process in Altnaglevin Area Hospital or the paediatric department.

I have enclosed the following material as requested:-

PSNI statement 13 /4/2006

Job description for paediatric SHO

Induction booklet for Medical Paediatrics- February 2001

Resuscitation training timetable from induction Altnagelvin Hospital 1999

Regional Neonatal Resuscitation training day booklet cover 26/3/01

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: Mary Butler. **Dated:** 14.6.12

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST

ALTNAGELVIN AREA HOSPITAL

JOB DESCRIPTION

1. **JOB TITLE:** SENIOR HOUSE OFFICER PAEDIATRIC MEDICINE - 1st TERM

2. **PURPOSE OF ROLE:** To support the Consultants in the provision of care to patients in the Altnagelvin Hospitals Health & Social Services Trust.

3. **MINIMUM QUALIFICATIONS:**

3.1 Full/Limited Registration with GMC (London) or eligibility for registration.

ALL DOCTORS MUST PROVIDE EVIDENCE OF REGISTRATION WITH THE GENERAL MEDICAL COUNCIL, LONDON BEFORE TAKING UP DUTY.

4. **KEY ORGANISATIONAL RELATIONSHIPS:**

4.1 The post holder will liaise with medical colleagues, nurses and other staff providing the range of services within the Trust.

4.2 The post holder will be managerially accountable to the Clinical Director and clinically accountable to and reporting to his/her consultant.

5. **STAFFING**

CONSULTANTS:

(1) Dr. R.J.M. Quinn M.B., FRCP
(2) Dr. D. A. Brown M.B., FRCP
(3) Dr. F.B. McCord M.B., FRCP
(4) Dr. N.P. Corrigan M.B., MRCP

1 Staff Grade

3 Specialist Registrars

1 2nd Term SHO

5 SHO's (including Trainee G.P.'s)

6. DUTIES OF THE POST

General care of the children in Ward 6, Infant Unit, Neonatal Intensive Care, Postnatal Ward, Labour Ward and Day Care Unit.

Attending at Out-Patient Clinics.

Discharge letters.
On Call duty rota 1 in 5.

Should take part in the General and departmental Postgraduate teaching. May be encouraged to assist in the teaching of nurses.

Opportunities for Clinical Research.

Should attend Junior Staff Committee Meetings.

Active participation in Junior Medical politics is to be encouraged and a representative from the Senior House Officer grade should be elected to attend Senior Medical Staff Committee Meetings.

Most duties in Altnagelvin Area Hospital.

The post is recognised for General Professional Training by the Royal College of Paediatrics and Child Health.

So far as is consistent with the proper discharge of the above duties the postholder must undertake to deputise from time to time for absent colleagues.

The postholder must undertake, exceptionally to perform additional duties in occasional emergencies and unforeseen circumstances.

The postholder must undertake, exceptionally to be available for such irregular commitments outside normally rostered duties as are essential for continuity of patient care.

7. STUDY AND TRAINING:

7.1 Junior doctors are expected to participate in the active teaching programme at the hospital. This includes tutorials, case conferences and journal clubs as well as weekly Perinatal meeting and other Medical Audit activities.

7.2 Library facilities are available (Branch Library Queen's University Medical Faculty),with a wide range of Journals and textbooks in all specialties. The

location of the library is in the Multi-disciplinary Education Centre Altnagelvin Area Hospital which is open as follows:-

9.00 am to 5.30 pm	Monday
9.00 am to 9.30 pm	Tues/Wed/Thurs
9.00 am to 5.00 pm	Friday

7.3 Study leave will be considered in accordance with the regulations and is subject to approved arrangements having been made for your duties to be carried out in your absence.

ALL LEAVE MUST BE APPLIED FOR ONE MONTH PRIOR TO REQUIRED DATES.

8. (a) THE HOSPITAL

Altnagelvin Area Hospital is a modern general hospital of 503 beds.

The major medical specialities are represented and there is a full range of Radiological, Laboratory and Paramedical services available on site.

The disciplines of Neurology, Neurosurgery, Plastic Surgery, Medical Genetics, Paediatric Cardiology, Paediatric Neurology and Radiotherapy are serviced by regionally based Consultants.

(b) THE WORK OF THE DEPARTMENT

It is a busy Childrens' Department with its own Wards and Out-Patients. Ward 6 has 43 beds/cots and NICU has 18 cots.

9. MAIN CONDITIONS OF SERVICE

9.1 The post will be subject to the terms and conditions of service for Hospital Medical and Dental Staff as agreed for Northern Ireland.

9.2 The post is a whole-time appointment. [redacted]

9.3 Membership of the H.P.S.S Superannuation Scheme is voluntary. There is a reciprocal arrangement between the N.I. scheme and that in operation in mainland Britain.

9.4 Must be resident when on call.

9.5 The passing of a medical examination is a condition of

the appointment.

As from 1 January 1990 the Altnagelvin Hospitals Health and Social Services Trust is financially responsible for medical negligence occurring in the course of a practitioner's Health Service Employment. A practitioner will be responsible for making his or her own arrangements to provide cover for non-NHS work. (APPOINTEES ARE ADVISED TO BECOME A MEMBER OF A MEDICAL PROTECTION AGENCY).

RESEARCH

Each unit has its on-going clinical research and participation will be welcome. Central funds may be available to assist approved research.

FACILITIES

Altnagelvin Area Hospital occupies a prominent site on the main Londonderry/Belfast road, some two miles from the City Centre and is served by a regular bus shuttle.

Adequate car parking is available adjacent to the accommodation.

Single accommodation is available on site and married accommodation may be available on site or within a short distance of the hospital.

When requested by applicant, arrangements can be made for applicant to visit the hospital.

THE TRUST OPERATES POLICIES ON SMOKING, ALCOHOL AND HEALTH.

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER.

ALL DOCTORS ARE REQUIRED TO:

1. **UNDERTAKE RESUSCITATION TRAINING.**
2. **ATTEND TRAINING SESSIONS.**
3. **PARTICIPATE IN AUDIT.**

FAILURE TO DO SO EXCEPT IN CASES OF CLINICAL NEED MAY BE HIGHLIGHTED IN FUTURE EMPLOYMENT REFERENCES.

Induction Booklet for SHO's in Medical Paediatrics - February 2001

Background information:

Altnagelvin Hospital Trust:

This is a large DGH serving a population of around 161,000. Consultant led services in all the major specialities are available on site. The comprehensive paediatric unit also has beds for general surgery and orthopaedics with plans to eventually incorporate all children's beds within the hospital. The medical paediatric team works closely with all other specialities especially radiology, surgery, dermatology, ENT and anaesthetics all of which have consultants with special interest in paediatrics. Full laboratory and radiological support including a CT scanner and soon to be opened MRI scanner are available.

Foyle Community Trust:

Foyle trust serves a similar population to the Hospital trust. It is responsible for the provision of the community paediatric and mental health services, including the child psychiatry and mental handicap service, in addition to the other responsibilities of a large community trust.

Altnagelvin Paediatric Unit:

This consists of 2 main clinical areas:
Level 6:
This is the comprehensive children's unit containing ward 6 and ward 16.

Ward 6 is the inpatient unit and is divided into:

The infant area: A 12 bedded area that receives infants from 2 days to 6 months of age.
General paediatric area: This is a 31 bedded area receiving children from 6 months to 13 years. The case mix reflects the nature of general paediatrics with a large catchment area.

Ward 16:

This contains the medical paediatric day case unit, medical paediatric outpatient area and consultant offices. There is also accommodation for parents of sick children.

Neonatal Intensive Care unit:
This is a modern neonatal unit looking after all in house deliveries and providing full and ongoing intensive care when required.
It provides 2 - 3 intensive care cots, 6 high dependency cots and 9 special care cots.

Outpatients:

Outpatient clinics are held in Altnagelvin hospital, Limavady and Strabane.

Case mix and turnover:

Number of admission's per year:	-	2200
Day case unit attendance :	-	2500
Number of outpatients per year:	-	New: 1000
	-	Review: 4400
Number of deliveries per year:	-	approaching 3,000
Number of admission's to NICU per year:	-	380

Staffing:

District Tutor-

Dr Neil Corrigan

Hospital:

Consultants:

	Special interest:
Dr Murray Quinn	Diabetes
Dr Des Brown	Neonatology
Dr Brian McCord	Asthma
Dr Neil Corrigan	Ambulatory paediatrics
Dr Cameron Imrie	Gastroenterology

Staff grade:

Dr Freda Mooney

SpR - x2

2nd term SHO - x2

1st term SHO - x7

Community:

Consultant -

Dr Sandi Hutton

SpR - x1

CMO/staff grades- x4.3 WTE

Baby Checks

- Usually one of the NICU SHO's is responsible for the baby checks. These should be done promptly each morning. The SHO responsible should be recorded on the Duty board in ward 6
- At the weekend the outgoing SHO is responsible for the baby checks
- If there is a problem D/W middle grade in NICU
- Documentation should be using the baby check proforma
- Vitamin K prescription must be completed in the medicine kardex (2mg orally 7-10 days after delivery)

Labour ward cover

- The SHO responsible for baby checks usually covers for labour ward also.
- Labour ward should be informed each morning who is providing cover

TPN

- TPN prescriptions should be completed each morning before 1500
- D/W middle grade if any difficulties

Phlebotomy

- Forms should be completed the previous night
- Phlebotomists will not use arterial lines, do blood gases or work with ventilated babies

Perinatal meeting (Wed. 11.45 in CEC)

- Subject will be decided by the middle grade
- SHO will organise overheads and do the presentation

Day Case Unit:

- This is run by [redacted]
- Duties include review of children post ward discharge e.g. F/U weight, pneumonia etc.
- Practical procedures e.g. insertion of IV lines for radiology patients
- If DCU is quiet the SHO should link in where help is required

Floater:

- Principally the floater will cover for holiday leave and days off in lieu of on call
- Flexibility and common sense will help!!

On Call

- There is double cover at SHO grade from 17.00 to 22.00
- One SHO is based in NICU/labour ward and one in general paediatrics
- This is to be interpreted flexibly and when one area is busy the other SHO is *expected* to help out
- Proper hand over by the SHO leaving at 22.00 is important
- The SHO on all night will take outside calls, admissions etc.
- *Please ensure all results are written into charts* the same night.
- The SHO on call all night should attend NICU at 0900 for the hand over and then proceed to ward 6/infant area for the hand over there

Annual leave and study leave:

Leave entitlement is per contractual agreement. It is easiest taken during your week of days. When this is not possible it is your responsibility to swap out of any evening, night or weekend commitments with your colleagues. Once agreed with everybody on the rota it needs to be approved by a consultant.

Generally this should work well. As a basic premise annual leave takes precedent over unstructured study leave.

Obviously leave takes some advance planning so don't leave it all to the last month!!

Altnagelvin Hospitals Health & Social Services Trust

TRAINING FOR SHO's AND REGISTRARS

Resuscitation Training Room - 1st floor beside canteen and opposite doctors common room

INTERMEDIATE LIFE SUPPORT	ADVANCED LIFE SUPPORT
Wednesday 4 August 2.00 - 5.00 pm	Tuesday 10 August 9.00 - 5.00 pm
Thursday 5 August 9.00 - 12.00 noon & 2.00 - 5.00 pm	Wednesday 25 August 9.00 - 5.00 pm
Friday 6 August 9.00 - 12.00 noon	Thursday 9 September 9.00 - 5.00 pm
Monday 9 August 9.00 - 12.00 noon & 2.00 - 5.00 pm	Thursday 7 October 9.00 - 5.00 pm
Thursday 12 August 9.00 - 12.00 noon	
Friday 13 August 9.00 - 12.00 noon & 2.00 - 5.00 pm	
Wednesday 18 August 2.00 - 5.00 pm	
Tuesday 24 August 9.00 - 12.00 noon & 2.00 - 5.00 pm	

Simulated cardiac arrest training sessions on the following dates from 12.00 - 12.45 pm: -

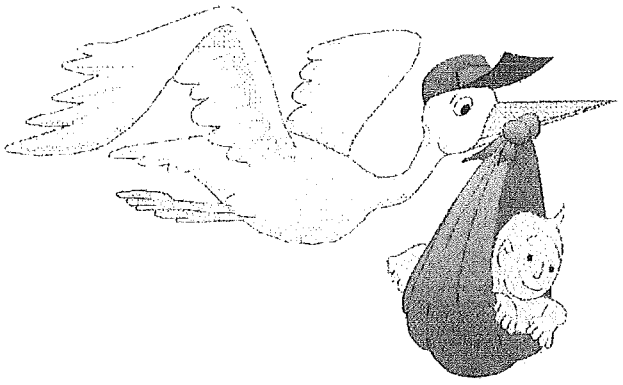
Wednesday 4 August 1999
Wednesday 1 September 1999
Wednesday 6 October 1999

Wednesday 18 August 1999
Wednesday 22 September 1999

NB. Resuscitation Training is a compulsory part of your contract.
UK Resuscitation Council ALS Course on 16 & 17 September 1999

URSULA McCOLLUM
Resuscitation Training Officer
[redacted]

REGIONAL NEONATAL RESUSCITATION TRAINING DAY



26th March 2001

Royal Maternity Hospital
Belfast