Witness Statement Ref. No. 035 /1

NAME OF CHILD: Raychel Ferguson

Name: Geoff Nesbitt

Title: Consultant Anaesthetist

Present position and institution:

Consultant Anaesthetist and Medical Director Altnagelvin Hospital

Previous position and institution:
[As at the time of the child's death]

Consultant Anaesthetist, Clinical Director in Anaesthesia and Critical Care Altnagelvin Hospital

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995-December 2004]
Altnagelvin Hospital Trust Board March 2002 to date
Altnagelvin Hospital Executive Committee March 2002 to date
Altnagelvin Hospital Management Team March 1998 to date
Altnagelvin Hospital Risk Management and Standards Committee March 2002 to date
Altnagelvin Hospital Ethics Committee March 2002 – March 2004
Altnagelvin Hospital Critical Incident Committee March 2002 to date
Altnagelvin Hospital Scrutiny Committee March 2002 to date

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

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

Ref:	Date:	
012-012-112	14.11.01	Statement
012-037-173	05.02.03	Deposition at the Inquest into the death of Raychel Ferguson

1. **Describe in detail your role in the treatment and care of Raychel Ferguson when you were called to ward 6 at 5.30am on 9th June 2001, to include:**
   (i) your concerns and observations in respect of Raychel;
   (ii) the steps taken by you as a result of those concerns; and
   (iii) your thoughts at that time as to the possible cause of Raychel's deterioration and her prognosis.

I am a Consultant in Anaesthesia and Critical Care. I was not on call but was contacted by the Anaesthetic Registrar, Dr Date, who described the situation in ward 6 where Raychel had been intubated and required ventilation following a respiratory arrest. The Registrar required assistance because the other anaesthetists on call were busy with another emergency and she had just been called to the maternity unit. I came in immediately and took Raychel to the Radiology Department where a CT scan was performed. *(Dr Morrison's note appears at 020.015.026)* Raychel remained intubated and ventilated and it was obvious that her condition was extremely serious, and the prognosis poor.

During the time taken to perform the CT scan, I reviewed the notes and gathered a history from the other clinicians present. It was not clear why Raychel had collapsed, the CT scan seemed to indicate cerebral oedema and the possibility of a sub-arachnoid bleed. Electrolyte measurement following her collapse showed severe hyponatraemia *(Document references 020.022.043 and 044)* and this was being treated using Normal Saline intravenously at a rate of 40 mls per hour. *(Document reference 020.019.038)*
During the time spent in the CT suite, I spoke with the neurosurgeons in Belfast who were able to view the results concurrently due to image linking. Following this conversation and at the neurosurgeon's request it was clear that Raychel would need to be transferred to RBHSC.

I contacted the Intensive Care Unit, explained the situation and requested that a bed be organized so that we could stabilize Raychel prior to her transfer to Belfast.

Following the CT scan, Raychel was taken to the Intensive Care unit. Notes made there indicated that Raychel was seriously ill but that her observations were stable. *(Document references 020.023.049, 050 and 051)* Following discussion of the CT findings with the Neurosurgeons in Belfast, a second CT scan, enhanced using contrast, was performed prior to transfer to the Royal Belfast Hospital for Sick Children. I accompanied Raychel to the CT suite for this second investigation and monitored her condition to ensure her stability throughout the scan.

We were all extremely concerned as to the cause of Raychel's brain swelling, one diagnosis suggested by the neurosurgeons had been that possibly a sub-dural empyema (an area of infection) had developed, and we hoped that surgical intervention might be possible.

Raychel was transferred to Belfast around 11am and I attended her throughout the journey. *(Document references 020.024.052, and 020.024.053)*

2. Describe in detail your communications, if any, with your colleagues at the RBHSC on 9th June 2001 both before Raychel's transfer and after.

Following my discussions with the Neurosurgeons, it was clear that Raychel would have to be transferred to the Royal Belfast Hospital for Sick Children and I contacted the intensive care unit there and spoke to the consultant on duty who I believe was Dr Chisakuta, a Consultant Paediatric Anaesthetist, outlining the history as above.

Following the transfer I handed over Raychel to the care of the intensive care team and gave them an update on the details of the case and a report of her condition throughout the transfer. There had been no change in her clinical condition during this time. I explained that my involvement with Raychel's treatment was from the time of her collapse but that I understood that she had had an uneventful appendectomy on the evening of Thursday 7th June and that initially she had made a good recovery. I outlined the course of Friday 8th June leading to her fitting and subsequent respiratory arrest in the early hours of Saturday morning. I gave a summary of the fluids administered including the change to Normal Saline to treat the hyponatraemia. The transfer had taken just over one hour and shortly after this time I returned to Altnagelvin Hospital.

I telephoned RBHSC either later that evening or possibly the following day, and spoke to Dr Crean, a Consultant Paediatric Anaesthetist, who informed me that brain stem function tests had confirmed that Raychel's condition was irretrievable. I expressed my shock and deep sadness that this had occurred following such a routine procedure.

During my investigation into the incidence of Hyponatraemia, and in the course of informing my colleagues in Hospitals in Northern Ireland of this tragedy, I contacted the RBHSC to ask about their use of No.18 solution. I believe this would have been around 13th June 2001. I was convinced that the use of a low sodium containing solution together with an abnormally high response to anti diuretic hormone, produced as a response to surgery, had contributed to the severe hyponatraemia and subsequent brain swelling in Raychel's case. I was informed that the RBHSC had ceased prescribing this fluid in postoperative children some 6 months previously but that, as in other hospitals, it had been the default solution up to that time. I requested that any data on hyponatraemia or the incidence of this in Northern Ireland would be helpful and Dr Taylor, a Consultant Paediatric Anaesthetist, agreed to send me these details.

3. Give details of your knowledge of hyponatraemia and the source of that knowledge prior to Raychel's death.

Prior to Raychel's death, my knowledge on the subject of hyponatraemia was gathered during my medical education and as part of my anaesthetic training.
Hyponatraemia is a term describing a low sodium level in the plasma. Sodium is the main positively charged ion in plasma and contributes to the serum osmolality. It has a normal range of around 135 – 145 mmoles per litre and hyponatraemia would, by definition, be a level below the normal. Severe hyponatraemia, likely to be symptomatic, would usually be a level less than 128 mmoles per litre. As an anaesthetist I would have been taught about electrolyte balance and of serum or plasma osmolality.
Cells require a balance between extra cellular plasma sodium and intracellular potassium, both of which are positive ions. If a cell experiences an imbalance such as might occur in hyponatraemia, then the plasma is relatively hypo-osmolar and the cell draws water into itself to dilute the intracellular potassium ion. This results in cellular swelling. The converse occurs if cells experience hyper-osmolar plasma such as occurs in hypernatraemia. In this situation the cell will give up intracellular water to the plasma in an attempt to balance osmolality. This results in intracellular dehydration.

The teaching on fluid administration has in the past emphasized the importance of fluids being isotonic, that is to say of a similar osmolality to plasma, so that the above scenarios and subsequent cellular damage would be avoided. Fluids of equal tonicity could for example contain water plus electrolytes, water plus a smaller amount of electrolytes but including sugar, or water and sugar alone. The emphasis would not have been on the sodium content specifically.

Hypernatraemia, a high sodium, would have been a recognized problem in paediatric practice often resulting from the actions of well meaning parents adding "one more scoop" to formula feeds for their infants. I was not aware of any teaching on the specific problem of hyponatraemia, particularly in reference to the care of surgical children.

4. Describe in detail your communications with the parents of Raychel Ferguson both before and after her death, to include:
(i) dates and time; and
(ii) the information that you gave to them and issues discussed.

I spoke to Raychel's mother in the Intensive Care unit in Altnagelvin Hospital following the CT scan. I think this was around 10am on Saturday morning, 8th June 2001. I explained that Raychel's condition was extremely serious and that we were unsure as to the reason for her brain swelling, which this scan had revealed. I told her that there was a possibility that there could have been a bleed into her brain (subarachnoid haemorrhage), and that we had contacted the Neurosurgeons in Belfast and were treating Raychel as they had requested. I explained that it would be necessary to take Raychel to the Royal Belfast Hospital for Sick Children so that the experts in treating her condition could take over her care. I tried to give whatever comfort I could but had to emphasise that the situation was extremely serious.

Prior to the transfer, which took place around 11am, I explained that it would not be possible for family members to accompany us in the ambulance. I explained exactly where we would be taking Raychel and that the transfer would be as fast as we could possibly make it. This was going to involve a police escort and I stressed that the family should make their way by car to RBHSC but should not attempt to follow the ambulance. This was for safety reasons and Raychel's mum said she understood this.

I next spoke to Raychel's relatives, including her mother, just prior to returning to Altnagelvin Hospital following her admission to RBHSC intensive care. The time was approximately 12.30pm. I told them that Raychel's condition had remained unchanged throughout the journey and that everyone would do what they could to look after her. I expressed my deep sympathy for their obvious distress and said that we would all be thinking of them and praying for Raychel's recovery.

Following the tragic news of Raychel's death in RBHSC, Altnagelvin Trust offered to meet with her parents to offer condolences and to help with questions, which they would inevitably have. Understandably this proved difficult for the Ferguson family and it was not until September when Raychel's mum felt able to attend such a meeting. I was present at this meeting and spoke frankly, openly and honestly to those present. No official notes were kept of this meeting but the Patient's Advocate representing the Ferguson family did keep a record. *(Document reference 022.084.215 – 224)* This however is not a full note of the meeting in that it does not include the opening remarks of both Mrs Burnside and myself where we clearly expressed our deep sense of sorrow and sympathy for the family following Raychel's loss. We stated that we were sorry that Raychel had died whilst in our care and stressed that the treatment she had received, which was the same as in other hospitals, would be reviewed, and whatever changes necessary be made as quickly as possible.

I expressed my sincere condolences and shock at Raychel's tragic death. During the meeting I remember answering why I thought Raychel had died. I tried to answer their questions sympathetically and as best I could. Where possible, I answered questions, which the family asked, relating to the surgery. I explained that although the Coroner had yet to state the cause of death, I believed that the cause was due to severe brain swelling following the development of a condition called hyponatraemia. I said that this was an extremely rare occurrence and one, which I had not seen before in a child. The fluid therapy, which Raychel received, was the same as that used in other hospitals, and the standards of care were the same as in other units treating children. On several occasions during the meeting we stressed that had we known then what we now knew following our investigation into the circumstances of Raychel's death, then perhaps the tragedy could have been prevented. I went on to explain all the steps, which we had taken so that such an occurrence would not happen again. I gave details of the discussions which I had with my colleagues in other hospitals treating children so that they would be aware of the risks of hyponatraemia, of how we had changed the fluid prescription in our children's ward, and of how I was introducing teaching on fluid management and the dangers of hyponatraemia to both nurses and doctors

within Altnagelvin Hospital.

I, along with Dr McCord, also spoke to Mrs Ferguson when we met at the Coroner's inquest in Belfast. We both at that time expressed our deepest sympathy and inquired as to how the family members were coping during what was a particularly difficult time.

5. Explain your understanding of procedures at Altnagelvin at the time of Raychel's death in relation to the prescribing of post operative fluids in paediatric patients, to include:
(i) whether initial post operative fluids were prescribed by surgical or paediatric medical staff;
(ii) responsibility for the monitoring of fluids prior to the issuing of further prescriptions; and
(iii) your input ,if any, into paediatric ward procedures in relation to fluids as applied in June 2001.

(i) Initial postoperative fluids are usually a continuation of fluids prescribed intra-operatively. This is usually instigated by the anaesthetist in theatre and taken over by the surgical team in the postoperative period. Paediatric medical staff would be present on the children's ward more commonly than the surgeons and, on occasion, might be asked to prescribe fluids.

(ii) Monitoring of fluids in the postoperative period would be the responsibility of nursing staff and prescription of further fluids, surgical staff.

(iii) I had no personal input into paediatric ward procedures in relation to fluid management as applied in June 2001.

6. Describe your role in the investigation carried out at Altnagelvin following the death of Raychel to include:

(i) details as to your understanding as to who initiated such an investigation, when and for what reason;

(ii) matters that you felt needed to be addressed; and

(iii) whether you consider the investigation was adequate.

Following Raychel's death, I spoke to the Chief Executive, Mrs Burnside, on Monday morning 11th June and informed her of the tragic events, which had occurred. Mrs Burnside relayed this information to Dr Fulton, the Medical Director, and asked him to set up an internal inquiry to investigate the events leading to such an unusual tragedy. The Critical Incident meeting, instigated according to hospital policy *(Document reference 026.012.016),* was arranged for the following day, 12th June 2001 and Therese Brown, the Hospital Risk Manager, informed me of this meeting. The reason for this meeting was to gather together everyone involved so that an accurate account could be made of the events leading to an unexpected death. This is Hospital Policy, and encourages accurate reporting of incidents in a blame free environment. The purpose of such a meeting is to establish a factual account, to investigate the circumstances and, where possible, to put in place measures to prevent recurrence.

I was concerned about the fluid administration and documentation around it. It appeared that the amount of fluid prescribed was too much for Raychel's weight. Raychel had been prescribed a rate of 80 mls per hour. By my calculation this should have been 65 mls per hour. However, initial fluid administration is often more than this figure to account for the fasting period prior to surgery. This fasting period results in a fluid deficit. Normal practice would be to replace one half of this deficit in the first hour together with the maintenance fluids, and the second half over the next two hours, again together with the maintenance fluid. I would have expected the rate to then be reduced following surgery. I was also concerned that the anaesthetic record documented 1000mls of Hartmann's solution in the "total fluid" box. *(Document reference 020.009.016)* This was clearly wrong and I had ascertained from the anaesthetists involved that the total given in theatre was 200mls and that the remainder had been discarded. On 13th June I asked that Dr Jamison, SHO in anaesthesia, add a retrospective note to the chart to show this correction. I countersigned and dated this correction.

I was also concerned about the type of postoperative fluid given to Raychel. Because of my involvement in Raychel's care following her collapse, and subsequent discussion with colleagues in RBHSC, I had investigated the role of No.18 solution in the development of hyponatraemia. I came to the view that No.18 solution was inappropriate for postoperative children and, prior to that time, was unaware that the fluids were routinely changed to this as the default solution in paediatrics. No.18 solution is not dangerous in itself but if excessive amounts of anti diuretic hormone are produced then the possibility of dilution of sodium could occur. In my view this might have explained the low sodium in Raychel's case. Raychel's sodium level would have been diluted by the retention of water as a result of anti diuretic hormone and No.18 solution, which contains 4% dextrose, could produce more free water as the sugar was metabolised. The problem would be exacerbated by sodium loss following vomiting. I believed that Raychel had displayed an unusual response, which resulted in severe hyponatraemia.

I felt that the meeting was conducted promptly, was informative and constructive. An action list was drawn up to address all the points raised during the meeting. *(Document reference 026.011.014)* I was charged with gathering information about the routine use of No.18 solution in postoperative children and I suggested that I contact other hospitals where children might be receiving this fluid, to warn them of the risks in the light of our experience.
Throughout the meeting I was struck by the feeling of shock and sorrow that such an unusual and tragic event could have occurred. All present agreed to investigate all aspects of the case so that, where lessons could be learned, steps would be taken to prevent a recurrence.
I believe this was a vital meeting and that the subsequent investigation was thorough, constructive and played a large part in the redesign of fluid administration in children throughout Northern Ireland.

7. Describe in detail the steps taken by you when you became aware of the suspected cause of Raychel's death, to include:
(i) communications with colleagues in other hospitals, trusts and the DHSSPS;
(ii) the dates of such communications;
(iii) the information you both received and imparted in those communications;
(iv) the nature of such communications; and
(v) the reason for such communications.

Following Raychel's death and discussion with colleagues in RBHSC, when it became apparent that the cause of death was cerebral swelling due to hyponatraemia, I decided to call colleagues in other hospitals where children could be treated surgically. I believe that I made telephone calls on 13th June 2001. I spoke to anaesthetic colleagues in several hospitals. I recollect speaking to Tyrone County, Antrim, Craigavon, and the Ulster Hospitals. This is not an exhaustive list of hospitals and I did not make a list of everyone I contacted. To those colleagues that I did speak to I outlined the events in Altnagelvin Hospital and indicated that a healthy child had died totally unexpectedly following an uneventful appendectomy. I explained in detail the fluid regime and in particular the use of No.18 solution as the default fluid in the paediatric ward. I remember specifically that the situation in both Craigavon and the Ulster Hospitals was exactly the same. Colleagues in both these hospitals expressed concerns that the very same conditions existed, and that they would take steps to see that changes were made as soon as possible. Craigavon Hospital said specifically that anaesthetists had been trying to prescribe Hartmann's solution as the postoperative fluid, but that as in Altnagelvin, the default solution meant that it was changed to No.18 on the ward.
I spoke to Dr Chisakuta, a consultant in paediatric anaesthesia and intensive care, in RBHSC about their use of No.18 solution in postoperative surgical children and he informed me that they had been using precisely the same regime as Altnagelvin Hospital but had changed from No.18 solution six months previously because of concerns about the possibility of low sodium levels. This was also the position in Tyrone County Hospital.

The nature of these communications took the form of a telephone call for information. I realized that steps would need to be taken at a regional level, and I was aware that the Department of Health were to be contacted by Dr Fulton, the Medical Director. However the urgency of the situation and my real belief that such an occurrence, however rare, could happen again if the same conditions existed, led me to have direct communication with colleagues, who might find themselves in a similar situation.

8. Give details of all steps taken by you at Altnagelvin after Raychel's death to ensure that as far as is possible any information or guidance that came to your attention following your researches and as a result of enquiries made were disseminated to medical and nursing staff.

Following the Critical Incident meeting held on 12th June 2001, I was asked to review the routine use of No.18 solution in postoperative children and to ascertain the practice in other hospitals in Northern Ireland. Dr Fulton requested that urgent recommendations be made following this review.

On 13th June 2001 I informed Dr Fulton and Mrs Burnside verbally that, following my research, I had decided to stop the use of No.18 solution in postoperative children. I wrote formally to Dr Fulton on 14th June 2001 confirming this decision. *(Document reference 026.005.006)* With their agreement, I informed Sister Miller in the children's ward of this decision and requested that steps be taken in the ward to effect this change. As a preliminary step, in Altnagelvin Hospital, a notice outlining the change in fluid to be prescribed and a chart to aid the calculation of a child's weight according to age were posted in the children's ward. *(Document references 026.010.011 and 026.009.010)*

The default fluid in surgical children became Hartmann's solution from that date. This information was shared with the Paediatricians, Surgeons and my Anaesthetic colleagues. Mrs Burnside was given a written update of the outcome of the critical incident meeting. *(Document reference 022.097.307)*

Initially there were some concerns expressed by surgical colleagues concerning the removal of No.18 solution and I addressed this by a letter to Mr Bateson giving my reasons for this decision. *(Document reference 022.098.309, and 026.014.028)*

Following discussions with my colleagues in the children's ward, a letter of consensus was drawn up and signed by all the Paediatricians and the Clinical Directors in Surgery and Anaesthesia. The default solution was changed to 0.45% Saline (half strength saline) in 2.5% dextrose at this time to address concerns that small children required some sugar which was not present in Hartmann's solution.

I undertook to provide teaching on the subject of hyponatraemia and fluid administration in children and prepared a computer presentation to assist me in this task. *(Document reference 021.054.117- 131)*

This presentation is approximately one hour in length and has been presented to many groups in Altnagelvin Hospital. My target is principally nurses and doctors but the talk has been presented to The Hospital Management team, Hospital Executive members, and I recall giving the presentation to the Trust Board of the hospital. I also gave this presentation to the Chief Medical Officer when she visited Altnagelvin Hospital on 14th January 2002. A similar presentation was given to the Western Health and Social Services Council on 19th February 2003. *(Document reference 023.044.004)* A copy of this version of the presentation was emailed to the Tribunal on 20/6/2005.

The teaching is an ongoing process and regular and I was most recently involved in the Medication Study Day in May 2005.

New doctors to Altnagelvin are given instruction in the administration of fluids in children and details are included in the Junior Doctors' Handbook. (Enclosed)

Posters on the subject of hyponatraemia and treatment guidance, issued by the Department of Health, are displayed throughout Altnagelvin Hospital. (Enclosed)

Where there are concerns around fluid prescription in children, either verbally from paediatric staff, or by the reporting of clinical incidents, these concerns are addressed immediately.

A fluid prescription chart (enclosed) has been designed, and is now in use in Altnagelvin Hospital, which addresses most of the concerns around calculation of rates and choice of fluid according to electrolyte measurement. It has been agreed with anaesthetic colleagues that fluids prescribed in theatre based on a preoperative electrolyte measurement can be given for up to 12 hours. This essentially ensures that fluids must be reviewed at 12 hours if they are to be continued. This would be a decision made by surgical staff and requires a blood test to decide the choice of fluid.

Further to a review of the critical incident meeting, on 9th April 2002, Dr Fulton outlined several questions, which he wanted covered. *(Document reference 026.002.002)* I was asked specifically to address who was responsible for prescribing fluids in children and for how long. A summary of issues to be addressed and actions taken are listed in Dr Fulton's letter. *(Document reference 022.092.299)*

On 1st May 2002, following this meeting, I issued guidance to all medical staff concerning the need for baseline measurement of electrolytes, and that anaesthetic staff were prepared to prescribe fluids for the first 12 hours only. Thereafter, fluids could only be prescribed on the evidence of a blood test measuring plasma sodium. *(021.049.106)*

On the same date, 1st May 2002, I wrote to the Chief Medical Officer, Dr Henrietta Campbell, asking whether or not there had been Department Guidance on the matter of fluid administration in children, following previous cases of hyponatraemia in Northern Ireland. *(Document reference 022.091.298)*
I received a reply on 10th May indicating that the first incidence of hyponatraemia which had come to the attention of the Department of Health, had in fact been that of Raychel Ferguson, and that there had been no guidance issued prior to this time. *(Document reference 022.090.297)*

On 9th May 2002, the default fluid was revised to half strength saline (0.45% NACL in 2.5% Dextrose), and a notice to this effect was posted in the children's ward. This also stressed the need for electrolyte measurement at 12 hours if fluids were to be continued. *(Document reference 021.048.104)*

A consensus statement was prepared and several drafts were circulated. *(Document references 021.051.109 –113 and 021.052.114)* On 28th May 2002 I wrote to Dr Brian McCord, Consultant Paediatrician, commending the protocol. *(A copy of this letter was emailed to the Tribunal on 20/6/05)*
Document 021.050.108 also includes a second page with signatures of Consultants treating children in Altnagelvin Hospital. This was not initially forwarded but has been sent to the Tribunal by email on 20/6/05.

Clarification of Hospital Policy on the administration of fluids in children was circulated to surgical colleagues, paediatricians and nursing staff on the children's ward on 2/5/03. *(Document reference 021.044.091)* The Medical Director and the Clinical Director in surgery signed this letter.

A letter from the Chief Medical Officer, seeking reassurance that guidelines had been implemented in Trusts throughout Northern Ireland, was circulated on 4/3/04. *(Document reference 021.043.089)* I replied to this letter confirming that, in Altnagelvin Hospital, this was the case. *(Document reference 021.041.086)*

A further reminder of the policy was circulated to all staff on 23/9/04. *(Document reference 021.039.082)*

9. Explain the part you played in the formulation and review of the Guidance issued by the DHSSPS in 2002 to include your opinion as to the adequacy or otherwise of the Guidelines.

I attended a meeting in Castle Buildings to review the use of fluids in the management of postoperative children. I am unsure of the exact date.

There was discussion around the type of fluid to be prescribed. My opinion, which I stated, was that the use of No. 18 solution should cease and that this should be highlighted in any guidance produced. There was much debate around this and the feeling was that there was no need to mention any fluid specifically since the guidance on the calculation of rates would ensure the correct volume, and guidance on the measurement of electrolytes, the choice of fluid to be prescribed.

The guidance does not state that No.18 solution should not be used and I think that for postoperative children, this statement should have been included. Whilst I agree that fluid administration in children requires a change in practice and not simply a change in fluids, and I state this clearly in my presentation on the subject, I still believe that avoidance of No.18 solution is desirable. My reason for saying this is that, if for some reason the guidelines are not followed, which clearly would be an error, then at least if the fluid contained enough sodium, hyponatraemia could possibly be averted.

I discussed my concerns about the draft guidance being prepared by the Department of Health with Dr Fulton. This was because of the failure to specifically highlight the potential dangers of using a low sodium containing fluid such as No.18 solution. Dr Fulton made Mrs Burnside aware of my concerns. *(Document reference 021.055.134)*
I had stressed the need for this to be made clear in the guidance from the Department of Health but no reference was made to any particular fluid. In a letter issued on 25/3/02, immediately prior to publishing the guidance, mention was made to a concern around the use of No.18 solution but stressed that all fluids were potentially hazardous. *(Document reference 026.019.046)*

One cannot argue, however, that the guidance issued by the DHSSPS is incorrect and if followed, I believe that fluids can safely be administered. However, in Altnagelvin I have with the agreement of my clinical colleagues, discontinued the use of No.18 solution throughout the Hospital.

Other points you wish to make including additions to any previous Statements, Depositions and or Reports
[Please attach additional sheets if more space is required]

All members of staff, medical and nursing, at Altnagelvin Hospital were devastated by the death of Raychel Ferguson. Her death, following an uneventful appendectomy and apparent recovery from her surgery, was completely unexpected and shocked all staff involved with her care.

Raychel's treatment was no different from any other child who required an operation, and the care given by nursing staff in the children's ward is of the highest standard. The use of No.18 solution was usual at that time and was used by most other hospitals treating children. The incidence of vomiting post surgery is not uncommon and this did not unduly alarm nursing staff when it happened to Raychel.

There was no guidance concerning hyponatraemia and this was a condition not seen by the majority of staff at the hospital.

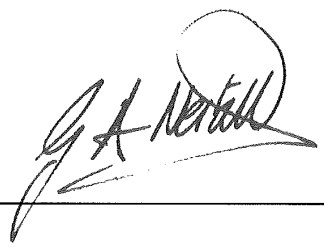
I believe that Raychel had an unusual and rare response to her surgery. Vomiting is difficult to quantify, but according to nursing staff, the amount was not out of the ordinary. Sodium loss by this route would contribute to her overall sodium level, but the dilution possibly caused by an excessive production of anti diuretic hormone may have had an important role to play in the development of hyponatraemia.

Having experienced this tragedy, Altnagelvin alerted other practitioners of the occurrence, and of the dangers of hyponatraemia associated with fluid management in children.

Altnagelvin has taken steps to prevent a recurrence by changing protocols around fluid management and by changing the default fluid to one containing more sodium. Measurement of electrolytes is mandatory before postoperative fluids can be prescribed, and the fluid charts include the accurate estimation of body weight according to age. Attempts have been made to accurately record amounts of losses although this is very difficult.

Altnagelvin Hospital is continually reviewing the prescription and administration of intravenous fluids in children. The education is an ongoing process

We have at all times been open and honest with the family, and express once again our condolences and heartfelt sorrow that Raychel died whilst in our care.

Signed: 

Dated: 20th June 2005

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The Altnagelvin Doctor's Handbook

Altnagelvin Hospitals

H&SS *Trust*

August 2004

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Foreword

Altnagelvin Hospital is a major district hospital offering a coherent range of high quality diagnosis, care and treatment skills and facilities to the population that it serves. You, as a Junior Doctor, are now employed here to learn from, and contribute to, the quality of diagnosis, care and treatment through your work in the specialty and through the learning opportunities that you will experience as part of the hospital team.

The success of your learning from all disciplines in the health care team will be influenced by the extent to which you actively engage with, and make the most of, the opportunities afforded you through supervision, discourse and dialogue, audit, lectures, seminars and tutorials. Alongside the structured education and the work experiences, Altnagelvin Hospital offers you a unique atmosphere of collegiality in which to learn and a social climate that is underpinned by the values of human decency and care for people who are our patients and our staff.

I warmly welcome you and hope that your contribution to the diagnosis, care and treatment of our patients will help you learn effectively and progress in your career.

Stella Burnside, Chief Executive

Welcome

Welcome to Altnagelvin Hospital. I hope you find your time with us both enjoyable and educational. This booklet is designed to complement your departmental induction and help you with some of the practical difficulties of settling into a new hospital and a new job. (This handbook may also be accessed via the hospital's intranet site, for ease of reference).

Life as a junior doctor is never easy. The new rota systems can seem confusing and time off a distant memory! The nature of life as a doctor means stressful events are commonplace. We pride ourselves in providing the very best care for our patients but death, dying and imparting bad news are always going to be a significant part of caring for the sick and their families.

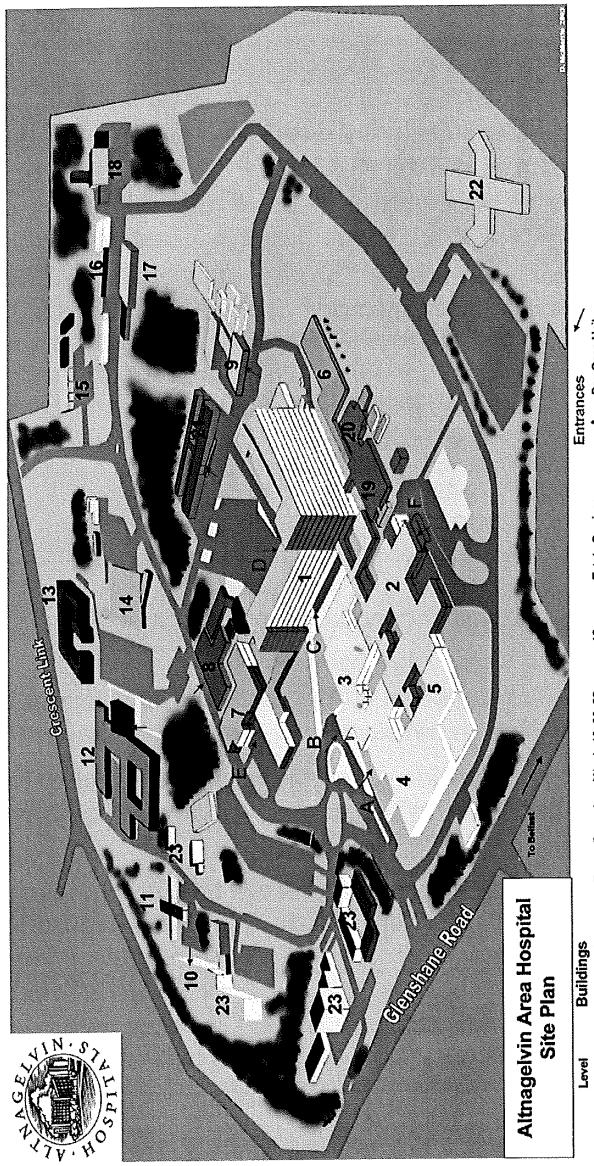
We want you to enjoy and survive your time in Altnagelvin. In this booklet you can learn how to order an X-ray, sort out a payslip and book your annual leave! It also gives advice on seeking careers advice from your educational supervisor and recognising and seeking help with stress or other illnesses from occupational health or other support services.

All of this is designed to complement the advice and support you will get from the senior staff within your own department.

The GMC, BMA and Trust provide guidelines regarding 'Good Medical Practice[1]', ethics and disciplinary procedures[2,3,4] that you should be familiar with.

If you have any comments or questions that will help us improve this booklet please send them to myself or Esme O'Brien the Postgraduate Secretary.

Neil Corrigan, Postgraduate Clinical Tutor



The Trust's facilities comprise:

• Altnagelvin Area Hospital	Acute Hospital Services 453 Inpatient Beds (current bed nos) 54 Day Case Beds
• Ward 5, Waterside Hospital	Slow Stream Rehabilitation 18 Inpatient Beds
• Spruce House, Altnagelvin *(New building opened in March 04 following relocation from Gransha Hospital site)*	Care of the Young Physically Disabled 17 Inpatient Beds

The Trust provides the widest range of acute secondary care services outside Belfast, and serves a population of some 200,000 for general hospital services and some 400,000 for specialist services, such as Trauma & Orthopaedics, Maxillofacial & Oral Surgery, Neonatology and Ophthalmology.

Altnagelvin Hospital is a designated cancer unit.

In order to maximise specialisation and to provide care with access for all populations, we have networked a number of our services across hospitals and health centres, in locations such as Fermanagh, Omagh, Magherafelt, Limavady, Coleraine and the central Belfast hospitals.

The Trust employs approximately 2,460 staff, with 215 of these in medical and dental posts*. The Trust's annual income is approximately £90m*.

Altnagelvin is a teaching hospital with a reputation for providing good quality undergraduate and postgraduate medical education, including GP Vocational Training. In addition, the hospital provides nursing and midwifery education, Allied Health Professional training and has the services of the North West In-Service Education Consortium on site.

Altnagelvin offers doctors in training the chance to be part of expert, cohesive teams working to the best modern standards and achieving national benchmarks.

*as at 2003/04 figures

A – Z of Personnel Issues

Accommodation:

The hospital provides accommodation for all the PRHOs. In addition there is a selection of single and married accommodation available. Details can be found by contacting Deirdre McDevitt, Site Manager or a member of the site management team at ext 3343/4573.

Annual leave:

As rotas become more complex annual leave needs more and more planning to allow service commitments to be met. Ideally, if leave is not pre-allocated, all leave requests should be made within the first 2 – 4 weeks of each 6-month attachment.

Entitlement:

Specialist Registrars >3rd point on scale	6 weeks
Specialist Registrars <3rd point on scale	5 weeks
Senior House Officers	5 weeks
Pre-registration House Officers	5 weeks

You must not exceed the number of annual or study leave days agreed in your contract.

All Junior Medical Staff must have a leave card. These can be obtained from the Medical Personnel Office.

*Requests for annual, statutory and study leave must **first** be approved by the relevant Consultant and leave card signed.* Where there are conflicting requests for leave, decisions by the nominated consultant will be regarded as final.

Final approval will be given by the **Clinical Services Manager** of your directorate.

Days in lieu of Statutory holidays worked must be taken as soon as possible following the Statutory holidays as such days cannot be aggregated.

Bleeps:

After the hospital induction all staff should pick up their bleep from switchboard near to the geriatric department. Some departments will have duty-specific bleeps e.g. the cardiac arrest bleep, labour ward bleeps etc. It is absolutely essential that protocols regarding the handover of such bleeps be rigorously adhered to. A breach of this could result in harm to patients and action against the doctor responsible.

Canteen facilities:
The canteen is situated on the first floor. Opening hours are as following: 8.00 am – 7.30 pm, and 11.00 pm – 2.00 am, 7 days per week. In addition, a coffee shop offering sandwiches and snacks is located in the front hall, ground floor, and is opened daily from 7.30 am – 9.00 pm.

Changes to personal circumstances:
Please let medical personnel know at ext 3396/3140, so records can be updated.

Contracts of employment:
Contracts should be issued within 4 weeks of starting. If there are any queries, contact Anne McIvor on ext 3806.

Compassionate Leave:
Details may be obtained from medical personnel.

Health Club:
The Trust has entered into a partnership agreement with the UK Civil Services Sports Council and opened their first Health Club in Northern Ireland at Altnagelvin Hospital, in October 2003. The Health Club boasts excellent facilities including a dedicated fitness suite, aerobic studios, beauty and therapy room and changing facilities. The opening hours and competitive membership details can be obtained from a member of the health club staff (ext 3055).

Job Interviews:

Leave to attend job interviews outside Altnagelvin HSS Trust **must normally be taken as annual leave** and with the usual permission from the supervising consultant.

Locum cover:

You may be required to provide cover for absent colleagues on an occasional basis. Where the absence is prolonged or predicted, medical personnel will endeavour to make alternative arrangements.

Monitoring of posts:

All posts will be subject to monitoring to ensure compliance with the junior doctor hours and EWTD regulations. You will be notified in advance when this monitoring is due to take place. You are **contractually obliged** to complete monitoring forms and return them promptly. Where there is a problem with compliance this should be discussed with your educational supervisor, college tutor or the postgraduate tutor – Dr Neil Corrigan (secretary ext 3318).

Payslips:

Salaries will be paid on the 3rd banking day before the end of the month. Should you have any queries regarding your pay please contact salaries and wages at ext 2372

Registration:

All Medical Officers must be registered or provisionally registered with the General Medical Council (UK). You are strongly advised to apply for membership of a recognised organisation for medical protection (MPS or MDU). This will give you legal protection in many instances that fall outside the Crown Indemnity Scheme. You should present your membership certificates to the Medical Personnel Office as soon as possible after your appointment. Acceptance of your appointment

will be taken as an indication that you agree with the terms of your contract. Please also note that the GMC will take a very dim view of doctors who leave the service without due notice, as this can seriously endanger the health of the patients under their care.

Study Leave[6]: General principals-

You should apply for your leave at the earliest possible opportunity. **Retrospective requests will not be considered**. There is a nominal amount of funding made available to each trainee by the postgraduate council - usually in the range of £500-700 depending on the year. Applications for study leave outside the hospital will be expected to conform to the educational objectives identified with your educational supervisor. Approval for such leave may be withheld if you have not attended local postgraduate medical meetings. Most general training courses are provided locally in NI, and as a rule SHOs will not be supported for courses elsewhere in the UK. It is in your own interest to use the cheapest form of transport available (within reason), and share private transport with colleagues where possible as the funding available to each individual is finite. The Postgraduate Clinical Tutor considers the advice of your educational supervisor and the guidelines issued by the Postgraduate Dean to assess whether or not your leave should be approved.

Entitlement:

Specialist Registrars

Years 1-3: one session per week study and research
Years 4-7: two sessions per week study and research
30 days per year (up to 15 in Training Programme)

SHOs

Maximum of 15 days per 6 months (not carried forward)

PRHOs

No entitlement to study leave. You may be allowed special leave to attend in-house training courses by your supervising consultants.

Applying for study leave:

When requesting study leave first complete the **SL1** form available from the **Medical Personnel Officer** and forward it to your Head of Department for signature. This is then countersigned by the Clinical Director and on to the **Medical Personnel Office**. They will then forward the form to the Secretary responsible for Study Leave and onto the Postgraduate Tutor for final approval. If you have been given a study leave booklet by the Northern Ireland Medical Training Authority (formerly the NICPMDE) in Belfast, attach this for completion as well. Please ensure that the SL1 form is accurately completed: alteration at a later stage may not be permitted.

Study leave for SpR trainees in all specialties needs to be **first approved locally before seeking approval and funding centrally from the Specialty Advisor to the Postgraduate Dean.**

Examination leave:

Funds will be available centrally to support travel and accommodation for legitimate postgraduate exams. **Examination fees are not redeemable**. Funding will generally only be available to support the first and second attempts and will not be granted if the doctor applying has already obtained the equivalent degree in another centre.

Sick Leave:

Medical staff who are unable to report for duty because they are sick must inform **the ward** on which they work (and if possible the Consultant) **and the Medical Personnel Officer** (ext. 3140/3396) prior to the starting time of shift.

The recent changes in junior doctors hours and the EWTD have resulted in a plethora on different, and at times, confusing rotas. Most of these now involve a form of shift working. This entails careful handovers between staff and good team working. It is your responsibility to ensure that an adequate handover is given. If a patient were to come to harm as a result of a failure of this handover you would be medico legally responsible. It is also essential that you adhere to the starting and finishing times, and that you take natural breaks if included as part of your rota.

It is best to find out the rota arrangements prior to starting work in the hospital!! This allows you to plan for late finishes or nights on call in the first few days.

A doctor from each tier of the rota normally draws up the rota although increasingly these are done in advance and allocated at the departmental induction. Copies of rotas are maintained in each department and in the telephone exchange. Completed rotas must be returned to the Medical Personnel Office 5 working days before the end of each. **Colleagues, ward staff, Medical Personnel and the telephone operators must all be informed of any changes** made to the rota. All staff that intend to take leave should inform the doctor co-ordinating the rota as soon as possible. If problems are anticipated with cover for whatever reason, inform the Clinical Director as soon as possible.

PRHOs and SHOs working on the same ward should not normally be on call on the same night, as this will deplete the ward cover for the following afternoon.

Pre-Registration House Officers

Normally **two Pre-Registration House Officers** will be on duty from 5.00 p.m. to 9.00 a.m., one 'Medical' and one 'Surgical'. On-call rooms are provided. It is **essential** that at all times senior colleagues are available for consultation and help within the hospital. The **Medical** Pre-Registration House Officer is responsible for Ward duties in the

Medical Wards (Wards 1, 2 and 3), and Medical emergencies occurring in the Surgical Wards as necessary e.g. Cardiac Arrests. He/she accepts all admissions to appropriate Wards. The **Surgical** Pre-Registration House Officer will be responsible for care of patients on the surgical admission unit and other Surgical Wards. He/she must inform the officer coming on duty the next morning, of any problems, especially at weekends.

Three tier cover rota (SHO, Reg, Cons)

A&E, Anaesthetics, Obs & Gynae, Paediatrics

Ophthalmology & ENT (Shared SHO)

Four tier cover rota (PRHO, SHO, Reg, Cons)

Orthopaedics, Surgery

Medicine (with two teams of SHOs)

Occupational health

All new doctors will have an initial contact with Occupational health as part of their pre-employment screening. You may also be referred after injury or illness or make a self referral. All records are confidential and will not be shared with your manager. This is separate from notes held by any treating doctor you have attended.

Pre-employment screening and exposure prone fitness:

There is a formal mechanism for establishing **exposure prone fitness** that forms part of establishing fitness for Employment. Until a certificate of fitness is issued you are unable to perform exposure prone procedures. You are strongly advised to take advantage of your **immunization update** call to the Occupational Health Department (ext 3533) so that any outstanding vaccinations and tests can be arranged.

Sharps injuries:

In the event of a sharps injury you are required to notify your employer by completion of an accident form and must seek medical assessment and treatment through the OHD (Accident & Emergency out of hours). Please note that it is hospital policy to test source blood for Hepatitis B, C and HIV. You may also be asked to take blood from another member of staff who has sustained a sharps injury. Verbal consent should be obtained from the patient and the conversation noted in the medical record. The purpose of the test should be explained, together with the fact that treatment will be offered if an abnormal test results. The patient can be reassured that life insurance will not be affected as long as the test is negative.

Self referral:

Staff support counselling line Tel. 0500 127079.

Doctors are notoriously bad at seeking help when unwell. Life as a junior doctor is very stressful and like the rest of the population you can get sick too. If you are worried that your health is or may be

affecting your work you should make contact with the OHD (ext. 3533). All contact is confidential and details will not be shared with your colleagues or managers. Alternatively the **B.M.A** has established a counselling service for doctors (Tel. 08459 200169). Another source of help is the **National Counselling service for Sick Doctors** (0870 241 0535). This service is available 24 hours a day, 7 days a week. Calls are dealt with by doctors confidentially and, if wished, anonymously.

If you may be at risk of transmitting H.I.V to a patient you must seek advice from the Occupational Physician.

Referral after illness or injury:

If there are concerns regarding your health by managers, either as a result of prolonged or repeated sick leave or concerns regarding your fitness to work, you can be referred to occupational health for assessment. All information is confidential to you apart from general advice regarding time required off work or dates of returning to work. This service is to support the doctor with problems and protect patients.

PRHO training:

The role of the PRHO is unique in that it is primarily a training and apprenticeship year, and as such represents the chance to put into practice what you have learned in theory. On the advice of the GMC and QUB, each of you has been assigned to a **supervising consultant**, who is responsible for carrying out interim and final assessments of your training using the **QUB assessment booklet**. You should meet with this consultant on a regular basis throughout the year to discuss your career plans and educational progress. In the unlikely event that your clinical performance gives rise to grave concern, these concerns will be discussed with you at an early stage to allow corrective action to be taken before the end of the year. We have been working hard to reduce working hours to the prescribed limits, and to ensure that routine tasks such as venepuncture can be delegated to others. Catering and accommodation should be satisfactory, and protected time should be provided for educational purposes. If there is any grievance relating to these arrangements, the PRHO is advised to seek the assistance of the overall **Educational Supervisor** (Dr J Moohan).

Attendance at the **induction course** for Pre-Registration House Officers is mandatory. Resuscitation training is offered to all PRHOs in their first few weeks.

Your educational supervisor will provide a programme of weekly talks on practical and emergency issues. A consultant in the relevant speciality will usually give the lecture or tutorial. We are committed to the principle of protected time for these sessions, and we ask for your commitment in attendance. It is the responsibility of SHOs in the unit to provide cover during this session. A record of attendance will be kept and reasons sought for repeated absences.

Postgraduate training:

All junior doctors are expected to attend the hospital induction course on the first day of your job. This will be supplemented by departmental induction.

Altnagelvin is deeply committed to the highest standards of postgraduate education and each department has a structured educational programme in addition to the hospital wide opportunities. All junior doctors are expected to participate in Postgraduate education and their attendance is recorded. This will form part of your appraisal and indeed failure to demonstrate sufficient attendances may result in funding for study leave being refused. Resuscitation training is mandatory for all trainees and refresher sessions are organised by the Resuscitation Officer, Ursula McCollum (ext 3387).

Education does not stop at formal training sessions and trainees should recognise and take part in the many other opportunistic training experiences available at ward rounds, handovers outpatients etc. There is an excellent publication by the postgraduate deans office exploring medical education strategies in the post EWTD environment called 'liberating learning' that I would highly recommend to all.

Resources in medical education:

The **postgraduate secretary** (ext. 3780) can help to point you in the right direction so that you make the most of the facilities available. Equipment to facilitate presentations includes photocopying facilities (including copying onto acetate sheets), Kodak slide projectors, VHS cameras and recorders.

The **library** (MDEC) has a wide range of books and journals as well as access to **Medline** and **Cochrane** databases. Current opening hours for the library can be obtained via the hospital intranet or by contacting the librarian on ext 3914.

The **Clinical Education Centre** is where most of the postgraduate teaching occurs. It also has facilities for video-conferencing.

The **Reading and Resource room** is in the Clinical Education Centre and is accessible from the main block 24 hours per day. It has computers and Internet access. Facilities on offer include access to Microsoft Office including Word and PowerPoint. This will help you to prepare articles and talks. You will also have access to Internet

Explorer as a Web Browser, and through the web you can access the online BMJ, Medline, Cochrane and a host of other medical education resources. Access to a number of useful CD-ROM textbooks is provided in this room.

Security precautions are necessary because of the expensive equipment provided. If you want to access the room after hours, you will need to apply for a security access card. Application forms for access card are available within this room, or may be obtained from the general site management office (ext 4573). This card will give access to the room and record this in a log.

Guidelines for the Resource room:

- Please look after your card and do not share it with anyone. If you observe any suspicious activity outside the room in the evenings, please report it to the porters immediately.
- Please use discretion when using the Internet. We are connected through an NHS firewall at 'DIS' in Belfast that monitors the access to sites. **Access and use of pornographic web sites or newsgroups through these computers is strictly forbidden**. We have an obligation to track and follow up any unauthorised internet use, which may result in the facility being withdrawn altogether. If you observe any member of staff using the internet inappropriately, please inform me without delay. You may use the internet to view 'non-medical' sites, but heavy 'recreational' use during working hours is discouraged. Playing internet games or listening to music will disturb other users and is also discouraged. Eating and drinking are not permitted in the rooms.

Teaching medical students:

Teaching medical students is an integral part of working in a teaching hospital. However, delegation of duties must be strictly limited: students should not prescribe drugs, and you must still complete a history and examination yourself (including documentation in the patients' notes), even if a student has initially seen the patient.

Consent:

Although most patients are only too happy to help in the teaching of students, some are not. It is important to ask them if they mind the presence of the student and to introduce the student to them. In the case of surgical procedures, the consent form mentions that students may be present. Please note that students should not normally play a major international role in the procedure.

Other Students:

Students on approved work experience placements from school may accompany staff on ward rounds or in theatre. The patient's consent must be obtained in all cases. You must be particularly careful not to disclose confidential information.

Appraisal:

Appraisal is now a universal requirement for doctors in training. For those of you within the SpR grades or within formal training programmes you will already be familiar with this fairly rigorous process.

For the rest of the junior doctors the DHSS has recently sent you the 'Appraisal for Doctors in training in the HPSS' folder. This reflects the categories within the GMC 'Good Practice' guidelines and will form the basis for formal revalidation in the future. In many cases, where the doctor is part of a college based training scheme, your college logbook can substitute this folder but you must clarify this with your college tutor first.

It is the responsibility of every junior doctor to ensure the appraisal documentation is completed. Without it revalidation will be impossible!

It is the duty of the Trust to ensure that the opportunity for appraisal is open to every junior doctor. The precise mechanism for this is unclear but it will most likely be organised through your educational supervisor in the first instance.

Arranging your appraisal:

You will be allocated an educational supervisor within 2 weeks of taking up post. It is your responsibility to organise an early meeting with your supervisor. It is the educational supervisor's duty to facilitate this. You will be expected to meet with your educational supervisor several times throughout your job. These meetings are designed to draw up a training plan and monitor your progress as well as formally completing the appraisal folder. Your Specialty College Tutor can provide you with further details. Repeated failure to attend appraisal meetings may be reported to the Dean and/or Royal College and finally will result in refusal of revalidation and the inability to work as a doctor within the NHS.

It is a GMC requirement to attend and **participate in audit**. Attendance at all meetings is monitored. This is a basic requirement of both appraisal and revalidation. The monthly hospital audit meetings as well as the audit meetings within your department form part of this training and attendance records are kept.

Taking part in clinical audit:

All junior doctors must be actively involved in audit. Generally this will be discussed and encouraged by your educational advisor. When you wish to carry out an audit please discuss this first with the consultants in your department. The **Audit Request Form** should be completed and returned to the clinical audit assistant. Help in retrieving charts and developing your data request form is available from the Clinical Audit department. (ext. 3466). Helpful advice can also be got from both your educational supervisor and tutor.

Research

The Trust is committed to enhancing the contribution of research to health and social care and encourages its staff to participate in research activity. Research is essential to the successful promotion and protection of health and well-being and to modern and effective health and social care services.

In encouraging and promoting the development of research at Altnagelvin, the Trust has appointed a Director of Research & Development. Anyone interested in, or willing to become involved in conducting research within the Trust, can seek support and advice through the Trust's Medical Education and Research Office (ext 4756.)

With the implementation of research governance in Northern Ireland, a Research Management System has been introduced within the Trust, with effect from 1 May 2004, when accountability for all research falls on the Chief Executive. The Research Management System enables staff to carry out research within the Trust in accordance with the new HPSS research governance requirements.

To this end, ALL research projects involving the participation of Trust employees, patients under the care of the Trust and the use of Trust facilities, staff and resources must therefore comply with the Research Management System, **BEFORE** permission can be granted for the research to commence. The Research Management System comprises the Research Management Policy, Process and supporting guidelines for staff to follow as approved by the Trust Board. The Research Management System is available through Heads of Departments, via the Trust's Intranet, or copies may be obtained from the Trust's Medical Education & Research Office.

All research projects should be relevant to the aims, objectives and priorities of the Trust. They must be ethical, of good scientific quality, and the risks to the Trust of undertaking the project must have been assessed and considered acceptable. As part of the management system, we have a registration and assessment process in place, designed to address the requirements of the new governance framework, which will ensure that all projects have been subjected to either internal or external peer review, have undergone scrutiny by a research ethics committee and have been costed by the finance department, so that financial implications to the Trust of undertaking the study would have been fully determined.

Consent issues

There is an obligation upon the doctor obtaining consent for a procedure to ensure that the patient has been adequately informed about the nature of the proposed procedure and any significant complications that may arise. In the case of major procedures, the person obtaining consent would normally be expected to have some practical experience and ideally should be the individual who is performing or assisting with the procedure. PRHOs should not be asked to obtain consent for major procedures. Signatures should be obtained on the (new) consent forms provided. In the event of a child under the age of 16, the parent/guardian will sign the form on their behalf. Patients have the right to refuse permission to examination and/or treatment: in this situation it is often wise to consult your senior colleagues. If an adult patient is unable to communicate their own wishes, a relative cannot provide consent on their behalf. A helpful booklet has been produced by the BMA on this subject (www.bma.org.uk-publications).

Altnagelvin Trust complies fully with the principles on consent contained in the DHSSPS handbook 'Good Practice in Consent' issued in March 2003 and requires that only the regional consent forms are used when written consent is necessary. The Trust has a policy (reference ProfPrac/04/001 effective 1st April 2004) and a Standards and Procedures document based on this guidance, which should be carefully read to ensure your practice is consistent with policy. Copies of these documents are available from consultants, clinical directors, or directorate managers.

Complaints Procedures

Patient's Advocate:

Complaints against doctors and other hospital staff are an increasing fact of life. Sometimes there are reasonable grounds for complaint, sometimes not. Bear in mind the psychological stress and / or guilt the patient / relative may be going through. As junior doctors in the 'front line' of care, you may be the subject of a complaint to the Patient's Advocate. The Patient's Advocate is there to take the comments and complaints of the public and act on their behalf to clarify the situation.

How to avoid complaints:

The best defence against complaints is good communication with patients and relatives. If you treat them with respect and understanding you will usually not face this problem. When talking with patients or relatives about complaints or sensitive issues, ask one of the nurses to accompany you and record the content of your discussion in the case notes.

How to deal with complaints:

You should contact the consultant in charge of the patient as soon as possible. If the consultant is not available, seek help from other senior members of the team. In general, you will not be asked to deal directly with formal complaints, although you may have to deal with minor and informal complaints on the ward. Please remember not to denigrate or implicate other members of the hospital staff or the hospital itself. If you respond to a complaint you may ask to see the report and/or correspondence to the complainant.

Reporting and recording of Accidents/Critical Incidents:

Every doctor will have to deal with critical incidents. These are occasions where there appears to have been a serious error or breakdown in care that has either led to harm to a patient or where such an outcome has been narrowly avoided. Identifying these situations may be painful or embarrassing for the staff involved, but you have a statutory and ethical obligation to report them. The lessons learnt can be vital in preventing a recurrence of the problem. It may require a change in the organisation of the hospital or department. You should always discuss any such concerns with your consultant in the first instance, and with his/her knowledge report the incident using the **Adverse Incident forms** available on each ward.

Our aims in identifying these incidents are to prevent a recurrence by addressing the core problems that caused the problem, not to create a 'witch-hunt' or scapegoat.

Accidents and minor injuries occur frequently in the Wards, and can have medico-legal consequences. An **accurate and legible record** in the case notes is therefore essential. The following details must be clearly stated: -

- Date
- Time
- Situation in the Ward where the accident occurred
- Names of witnesses

If there are no witnesses, state this and record the name of the person who first found or was called to the patient. Give details of external injuries and advice for x-ray examination if indicated. The record must have a legible signature.

Police and/or Press:

The general rule is that 'under no circumstances should information regarding a patient be given to anyone without the patient's full knowledge and consent'. The **only exception** to this rule is when the

police request information on patients regarding a crime of sufficient gravity for **public interest** to prevail. Further details are provided in the Accident and Emergency handbook.

All enquiries from the police should be referred to the Trust's **Police Liaison Officer** (ext 3311) during normal working hours or the Senior Nursing Officer / Hospital Services Manager outside these hours.

All media enquiries must be directed to the Trust's **Communications Manager** (ext 3429) during normal working hours or the Senior Nursing Officer / Hospital Services Manager outside these hours. A medical officer can be sued for damages for breaches of professional confidence. All solicitors, their agents or other parties requesting information regarding a patient should be referred to the consultant concerned. If the police ask to interview a patient, seek advice from senior colleagues/Risk Management Team and record a summary of your discussions in the notes.

Deaths reported to the Coroner are investigated by the PSNI acting as Coroner's officers. Requests on behalf of the Coroner for statements where treatment in hospital prior to death may be questioned should be referred to Mrs T Brown, Risk Management Director. **Do not give statements direct to the Coroner's officer (usually a local Police Officer).**

Case note recording:[8]

- All entries in case notes must be timed and dated. **Entries must be easily legible and written in dark ink. Each entry should be signed and the name printed beneath the signature**. Retrospective alterations to the notes should only be made in exceptional circumstances, and then must be signed and dated with the original entry legible, but scored out with a single line. Use only approved abbreviations, and above all avoid making derogatory comments about patients or other members of staff in the medical record. The entries and the signature **must be legible**. The Medical Personnel Office will keep a registry of signatures for future reference.
- **History** taking: Where helpful information may be gained from a third party, e.g., witness to a "blackout", carer of an elderly or unconscious patient, this must be obtained and documented.
- The admitting doctor should give his impression at the end of writing up the case in the form of a **differential diagnosis**.
- A "**Problem List**" should be formulated.
- Regular daily notes after admission should be made, documenting the progress of the patient's illness and how the results of investigations have confirmed or altered the differential diagnosis.
- The use of ancillary services should be noted.
- **A record should be made of the content of discussions with the patient and relatives**.
- The arrangements and the indications for follow-up should form a summary at the end, together with clear documentation as to the therapy that is to be continued on discharge from hospital.
- All typed correspondence must be checked and signed by the doctor who dictated them. Any corrections should be made on all copies of the correspondence.

Discharge summaries:

Each department will have its own discharge summary policy. In most cases the hand-written summary should be sent with the patient with

clear instructions to take it to the GP as soon as possible. **This summary should be legible and accurate:** In routine cases consider ticking the section, which indicates that a typed discharge letter is not required. This can significantly reduce the medical and secretarial workload. Often a typed discharge summary is required and should be completed as soon as possible (ideally within 4 days). Discharge summaries should contain the following details:

- A concise summary of the reason for admission.
- The results of important investigations that enabled the diagnosis to be made.
- Diagnoses, with sufficient detail to permit accurate coding.
- Procedures, with sufficient detail to permit accurate coding
- Therapy to be continued after discharge.
- The G.P. must be informed how much information has been conveyed to the patient and how much to the relatives.
- A clear statement of follow-up arrangements.

Deliberate Self Harm:

Psychiatric assessment is essential for everyone who has taken a definite overdose with deliberate intention of self-harm. This should be obtained prior to release from hospital if at all possible. An overdose assessment service is provided through Gransha Hospital daily including weekend (contact via switchboard)s.

Discharge against medical advice:

In some cases patients will leave the ward against medical advice. If a patient admitted with deliberate self-harm wishes to discharge himself "contrary to medical advice" then careful consideration of patients' mental state is important. If you feel that the patient has a mental illness and is a risk to himself or others and does not wish to remain in hospital voluntarily you should consider formal admission. You should consult the duty officer in Psychiatry to seek advice on 'formal detention' (see below). In all other cases, if a patient is determined to leave "contrary to medical advice", you must **detail in the notes your explanation of the risks involved** and if the patient left in the company of a friend or relative. If such a patient refuses to sign the

"CMA" form, witnesses to this effect should be obtained. **You must contact the patient's General Practitioner** (or locum) as soon as possible to inform them of the patient's departure. If a patient leaves the ward in a confused state, it is important to inform security and, if necessary, the police. Do not attempt to confront a patient who is acting violently: avoid direct eye contact and attempt to defuse the situation. Call security for assistance and report the incident.

Formal detention of a patient in a general hospital:

- A patient can be **formally detained** using the Mental Health Order if they are suffering from a mental illness, are a risk of serious self-harm or a risk towards others and do not wish to remain in hospital voluntarily. This allows the patient to be held in hospital against their wishes and if necessary **treated for mental illness only**.
- The mental Health Order May not be used if a patient **insists on trying to leave hospital** and staff believe he/she is a serious risk of either becoming **seriously ill or indeed dying from the effects of an overdose**. These are physical conditions and the mental health order can only be used to teat mental health problems. These situations are difficult but must be treated under common law. In this situation you should seek senior advice!!
- Physical treatment can be carried out under common law where the doctor acts in the best interest of the patient to prevent serious ill harm or death. The reasons for treating someone who has been refusing treatment should be clearly recorded in the case notes. He/she may have to be monitored and staff may have to wait until there are effects of the overdose i.e. semi-consciousness, before staff can state that they had to intervene to save the individual's life.
- Form 5A: **'Medical practitioner's report on hospital in-patient not liable to be detained.'** will detain a patient for assessment. This will hold someone for **48 hours** while the other forms required are being signed (forms 1 or 2, plus 3). A Form 5A is not sufficient to transfer a patient to another hospital, i.e. if they require transfer to Gransha Hospital. **Forms 1 or 2 plus 3** must be completed before transfer.

- Form 1: the nearest relative completes **"Application by the nearest relative for admission for assessment"**. There are notes for guidance on who is the "nearest relative" on the reverse side of the form.
- Form 2: **"Application by an approved social worker for admission for assessment"**. If the next of kin is not available or does not sign the form himself, an approved social worker can be asked to see the patient instead. In this case Form 2 is completed if the social worker agrees that he/she needs detention for assessment.
- Form 3: **"Medical recommendation admission for assessment"**. If the patient's own GP is not available to complete form 3 (this would be the first preference), a doctor on the staff of Altnagelvin Hospital can complete this form, provided they have full GMC registration. The Form 3 is completed before the Form 1 or 2.

Points of note:

- **Form 5A** can only be completed by a fully registered doctor on the staff of the general hospital
- **Form 5A** can only be used on an in-patient, and not on an outpatient or someone attending an accident and emergency department. There is no such holding power for outpatients and the normal admission process must be used.
- **Form 5A** should only be used if there is a possibility that the patient could seek to leave hospital before the normal application can be completed.

Notification of Infectious diseases:

When a diagnosis of infectious disease is made, the Department of Public Health Medicine must be advised using the prescribed Notification Certificate, supplies of which are available at Ward level or a member of the Infection Control Team. A list of currently notifiable diseases is given in the appendix to this handbook. In the case of suspected meningococcal infection, the doctor concerned should **inform the Consultant in Communicable Diseases immediately by telephone** (via switchboard).

Infection control:

A specialist infection control officer is available to offer advice, especially where there is a particular risk of cross-infection e.g. MRSA. Please remember **to wash your hands thoroughly after examining patients** and take appropriate precautions when dealing with infected areas. Infection control manuals are held on the wards.

It is also vitally important to **take precautions when handling blood** (such as wearing appropriate gloves) or blood products, especially in patients who are likely to carry Hepatitis / HIV. The most important factor is **sharps injury**, so do your utmost to ensure that used needles are safely disposed of in the appropriate sharps container.

Theatre lists:

1. Unless alternative arrangements have been made, Theatre lists should be compiled on the Operation List Form, OL.198, which is available in Surgical Wards. This form should be completed legibly and in its entirety. It should be carefully checked before submission.

2. Theatre lists must be made available to the Anaesthetic Staff in time for routine pre-operative visits.

3. In addition to the copy of the list, which is submitted to the Theatre co-ordinator, at least one duplicate copy will be required for Anaesthetic Staff.

4. When a theatre list has been organised, the Anaesthetist in charge must be notified by the House Officer or Senior House Officer in the event of the following: -

(a) Cancellation of the list

(b) Any alteration in the order of patients on the list

(c) Any late additions or deletions

(d) Where a patient is likely to be admitted after a list has commenced, e.g., for minor day-stay surgery, it is the responsibility of the House Officer to inform the Anaesthetist of the patient's clinical status on admission.

Dental care:

Patients requiring routine dental care whilst in Altnagelvin Hospital should receive such care from their own General Dental Practitioner. Most General Dental Practitioners are quite prepared to visit their patients in hospital.

If a patient is not registered with a General Dental Practitioner there is a Community Dental Officer who is responsible for providing routine dental care for such patients. At the present time the Community Dental Officer is in Altnagelvin on a Friday and is prepared to visit patients in the ward to help with their routine care. They will also in certain circumstances visit patients in the ward at any time during the week if it is felt that urgent treatment is required.

The Oral & Maxillofacial Surgery junior staff are available to help with patients who are in acute pain, are bleeding or thought to have a spreading infection. Referrals for any oral or facial condition thought to be outside the remits of the average General Dental Practitioner are also welcome at any time.

Sharps:

We have an obligation to our patients, staff and general public to ensure a safe environment. All contact with sharps should be minimised. All disposable sharp instruments should be discarded in an appropriate sharps container immediately after use. Incidents involving sharps should be reported and appropriate incident forms completed.

Violence:

Patients who become violent should not be confronted. There are guidelines on the management of violent or potentially violent situations and you should be familiar with them. Some provisions have been made in the A&E department to minimise the risk to staff, but please do not rely on the porters to manage violence by themselves. Please don't forget to fill out the incident forms so that problem areas can be identified.

Some useful recommendations are as follows:

- Be alert to warning signs of impending violence: anticipate trouble
- Attempt to defuse potentially violent situations
- Do not meet violence with violence
- Avoid verbal or body territory confrontation
- Avoid becoming trapped in a confined space
- Get help from other members of staff
- PSNI assistance may be required and is available
- For Psychiatric patients consider medical restraint
- Ensure that accurate records of the episode are kept
- Report the episode to Senior managers

Procedures[13]

As a junior member of the medical staff, an important part of your training is learning new procedures. It is important to ensure that you have adequate supervision and guidance before undertaking these procedures on your own, whatever the time of day or night. Be sure to acquaint yourself with any local guidelines.

Prescribing:

Prescribing medication is one of the most important duties as a junior doctor, and mistakes in this area can be disastrous for the patient, and lay you open to litigation. The following general guidelines may help, but remember to ask a senior colleague and consult the British National Formulary (BNF) if you are in doubt.

Accurate and safe prescribing[11]

Your prescriptions must be accurate and legible. You should read and put into practice the advice given in the BNF 'General Guidelines'. In general: -

(i) Write **legibly** and avoid abbreviations. Full signatures are required, not initials.

(ii) Avoid using **proprietary names** where possible, and use **metric units** without decimal points where possible (Digoxin 125 micrograms rather than 0.125mg). Microgram should be written in full to avoid confusion.

(iii) Check drug doses, dose intervals and route with great care.

(iv) Check for drug sensitivities, record clearly in red.

(v) When re-writing a kardex, use the date when the prescription was **first initiated**. Cancel the prescriptions on the old sheet, using a single straight line through each entry, dated and initialled.

(vi) When a patient is admitted, take care to obtain details of their previous prescription and continue drugs at the appropriate dosage where necessary.

(vii) When initiating a new drug you have little experience with, ask a senior colleague before making a major change in therapy. You may also wish to ask the advice of the Pharmacy department who can research the literature on side effects and interactions of new or less commonly used drugs. Always record the reasons for initiating therapy in the medical notes and inform the nursing staff. Inform the General Practitioner of these indications and of how long you intend the patient to take the medication. The

patient should also be fully informed about their medication, and where the drug is particularly toxic, you should provide specific patient information and record that you have done so.

(viii) Take particular care with **calculations** of drug dosage (by age, height or weight). You must record clearly the patient's height and weight and the calculation you have performed to arrive at the dose. When you find yourself giving more than three parenteral dosage units (i.e. three ampoules or vials), check first with the Pharmacy department.

Adverse reactions:

It is vitally important that you obtain a history of adverse reactions to drugs when a patient is admitted and when a new drug is prescribed, especially penicillin related drugs. Record the nature of the adverse reaction to give some idea of its severity.

Some adverse reactions (to new drugs, or severe reactions to established drugs) must be reported to the Committee on Safety of Medicines. Please refer to the appropriate section in BNF for guidelines.

Hospital Formulary: 12

A hospital formulary should have been given to you on taking up post. These guidelines are based on good practice and revised frequently, so you should use them as often as possible. Advice on the management of infections can be obtained from the Consultant Microbiologist.

Medication on Discharge:

Take care to ensure that your prescription is accurate and legible, and that the patient is given instruction on any new treatments. Do not prescribe night sedation that was intended for hospital stay only.

Anti-Coagulation:

If your patient has been commenced on anti-coagulants, you **must** fill out the form for the anti-coagulant clinic and contact the clinic to arrange the first appointment. The form should include the diagnosis,

the target INR, and the proposed duration of anti-coagulation. Patients should be informed verbally and in writing of the nature, adverse effects and potential interactions of their therapy. An information leaflet is available, and this must be given to the patient prior to discharge from hospital.

Pharmacy: A valuable Information service:

The Pharmacists are keen to help you and give advice where you are unsure of dosage etc. They will also perform literature searches to investigate possible adverse reactions to medication.

The Pharmacy has a Medicines Help line (0800 9178600, or 028 71329733) for the benefit of patients.

Prescribing IV fluids:

Prescribing IV fluids is a potentially hazardous duty. Close attention should be given to the type and volumes of intravenous fluids required and any related ward policies. For example, the default solution for paediatric patients is now half strength saline in 2.5% dextrose. This is to reduce the risk of ISADH related hyponatraemia that can be fatal. **If you are unsure of your fluid prescribing seek senior advice.**

Administration of Blood Products:[13]

This is one area in which a junior member of staff can very easily cause a patient's death by a moment's inattention or carelessness. Constant vigilance and care is the key to avoid mistakes. It is vital that you are familiar with the hospital's **blood transfusion policy**[13]**.**

When you take blood for group and **cross-matching**, it is vitally important that you **check the patient's name and date of birth** verbally and by checking the patient's identification bracelet. Cross-matching tubes must be handwritten at the bedside – addressograph labels will not be accepted. You should also check for previous adverse reactions to blood products. **Do not delegate these duties**. The correct and full documentation of blood administration is a legal requirement.

Before administration of blood products, check that the patient needs the transfusion. In the case of chronic anaemia, iron or vitamin B_{12} replacement may suffice. Once again, check the patient's name, number and date of birth: also check the blood products bag for the blood group and expiry date.

Administration of Chemotherapy:[9]

Guidelines on the administration of chemotherapy are available in the Chemotherapy unit. **Please do not undertake to administer chemotherapy without adequate supervision if you have not been trained.**

Please note that hospital policy states that **intrathecal chemotherapy may only be administered by a consultant haematologist.**

Death and Dying:

A palliative Care Service is provided within the Trust. This service for adult patients is co-ordinated by Dr A Garvey, Palliative Care Consultant and nurses Mandy Bradley and Claire McGuigan, Specialist Palliative Care Nurses. The remit of the palliative care team is to support ward teams in caring for patients with cancer at all stages of their cancer journey from diagnosis through to terminal illness who have complex symptom control, emotional, social or family needs. Patients should be referred using the palliative care team referral form which is sent to the secretary Lisa McConalogue, c/o Ward 19. Urgent referrals can be processed by bleeping one of the members of the palliative care team. It is important that the patient is aware of the referral. You will find regional guidelines for the control of pain, regional guidelines for breaking bad news and regional guidelines for the care of the dying patent on the hospital intranet. You can access these by clicking on Altnagelvin E-Department, then click on Oncology and finally click on Palliative Care. You should familarise yourself with these guidelines.

Breaking bad news to a patient:

There is never a good time to break bad news, but skill, tact and empathy are needed to minimise its traumatic effect. The patient who clearly requests accurate information regarding their diagnosis and prognosis has a right to be told the truth and this should be done in private, and with an accompanying family member if that is the patient's wish. You should familiarise yourself with the regional guidelines in breaking bad news. The Patient's General Practitioner should be informed when bad news is given to a patient. Equally, patients who indicate that they do not wish to know their diagnosis or prognosis should have these wishes respected. If important news has to be broken to the patient it is often best to arrange for the consultant in charge to speak to the patient.

Breaking bad news to the family:

You will at some stage be asked to speak to grieving relatives just after the death of their loved one. In this circumstance, you should confirm the facts about the patient and the identity of the relatives before speaking to them in the presence of one of the nurses. You do not need to say very much, but even if you are under pressure, it is important to spend a few minutes with them and to respect their grief.

'Do Not Resuscitate' Policy[14]:

You must familiarise yourself with the hospital **"Do not Resuscitate policy"**. Do not make a 'DNR' statement in the medical record without first referring to this policy and consulting with senior colleagues.

It is important for all clinical doctors to attend the regular Resuscitation training sessions provided and to ensure that they keep up to date with the latest guidelines. Please contact the **Resuscitation Officer** for further details. Where your Speciality Training committee advises official resuscitation training courses. Please ensure that you have attended these.

Making wills:

It is recommended that Medical and Nursing Staff are not involved in the witnessing of wills. It may be held in the event of a will being contested that staff somehow imply a greater warranty on a patient's physical and mental competence at the time the will is prepared than would be the case if the will was witnessed by 'lay' staff.

Certifying the Death of a Patient:

The Nursing Staff have been instructed that a patient who appears dead must not be removed from the Ward until a Medical Officer has confirmed the death. If you are not a member of the medical team involved in the care of the patient, you are only required to certify the patient dead and there is no necessity for you to issue the death certificate. Please speak to the nursing staff to familiarise yourself with the circumstances before approaching the patient, and show courtesy to grieving relatives.

Death Certificates:

Death certificates should be signed by a medical officer involved in the care of the deceased prior to his/her death. The diagnosis or diagnoses should be clearly recorded according to the guidelines on the certificate book. If there are any queries, these should be directed at your senior colleagues in the first instance. Before you sign - ask yourself if a hospital autopsy would be helpful or if the death should be reported to the Coroner? You are signing a legal document and are expected to identify those who should be referred to the coroner.

Cremation Certificates:

Cremation certificates have several parts, and instructions must be carefully studied before signing. **Part B** is to be signed by a doctor who was present at the death of the patient. It is this doctor's responsibility to ensure that the cause of death recorded is accurate to the best of their knowledge, and that there is no hint of foul play. They should also take care to check that the patient is not fitted with a cardiac pacemaker, as they could be found liable for a subsequent explosion! **Part C** must only be signed by medical practitioners who have held **full GMC registration for at least 5 years** and who are not members of the team responsible for the care of the patient. This doctor must ensure that they speak directly to the medical officer who filled in the first section to ascertain the cause of death, and that they examine the body to confirm death. Fees are payable for completion of the certificate, and you should declare these in your annual tax returns.

When should the Coroner be informed of a death?

There is a **statutory duty** upon every Medical Officer immediately to inform the Coroner when there is reason to believe that the deceased person died in unusual circumstances. Examples are outlined below:-

- The cause of death is uncertain
- Death was sudden, violent or caused by an accident or misadventure
- As a result of **negligence or misconduct or malpractice** on the part of others

- From any **cause other than natural illness or disease** for which they had been seen and treated by a registered Medical Practitioner within **28 days** prior to their death
- In such circumstances as may require investigation (including death as the result of the administration of an **anaesthetic** or immediately following an **operation**)
- Was suffering from a **notifiable industrial disease** (e.g. Asbestos related disease)—even though it was not the cause of death.

Cases must be referred to the Coroner when death occurs in hospital, if

- Death has, or might have, resulted from an accident, suicide or homicide
- There is a question of negligence or misadventure regarding the treatment the deceased received
- The patient dies before a provisional diagnosis is made and the General Practitioner is also unwilling to certify the cause.

Before notifying the Coroner, the advice of an experienced colleague should be sought. The member of the Medical Staff should also inform the Consultant in charge of the patient. A **clinical summary must be prepared** for the state pathologist, but again a senior colleague should review this where possible. You do not have to obtain consent from the relatives, but must always take time to inform them about what a coroner's post-mortem / inquest involves. If you are asked to provide a statement by the Police acting on behalf of the Coroner, you are entitled to make a written statement but first seek advice from the **Trust's Risk Management Director** (ext. 3311) and/or your own medical protection society.

Where a death is reported to the Coroner it is purely a matter for the Coroner should he decide to arrange an Autopsy with the Forensic Pathologists. In those cases where the decision is at the discretion of the Coroner, it is especially important that you keep the relatives informed. Requests for information regarding the result of a coroner's autopsy report should be directed either to the Coroner or to the Forensic Pathology Department in Belfast. The Laboratory and the

Hospital Pathologist should not be contacted in this regard.

If you are called to give evidence in a Coroner's court or prepare a report for the Coroner, you should first discuss it fully with your consultant, the Trust's Risk Management Director and/or your own medical protection society. **Do not release any report to the police or Coroner without showing it to the Trust's Risk Management Director.**

When should I ask for a hospital autopsy?[15A, 15B]

Never sign a death certificate without considering if there is a potential benefit from a hospital autopsy - this is particularly relevant if the patient is not known to you. Hospital autopsies (see below) have an important role in post-graduate education and in the audit of the quality of medical care. In many cases the patient has been undergoing investigation for a natural illness, but the exact nature of the problem is unclear at the time of death. When a hospital autopsy is thought to be of potential benefit, the doctor involved at the time of the patient's death should exercise sensitivity in speaking to the deceased's nearest relative to obtain signed consent. The hospital has a detailed information and consent form for hospital post-mortems, which you must explain to the relatives. You should not attempt to coerce the relatives to give consent or threaten them that if they do not consent it will be a Coroner's case. You should familiarise yourself with the **'Guidelines on retention of tissues and organs'**[15A, 15B] and be aware of the sensitive nature of the subject.

There is a separate protocol listed for obtaining a hospital autopsy and these are available on each of the wards. Briefly, **hospital autopsies must be arranged directly between the doctor involved and the Pathologist**. This should not be delegated to Nurses or Mortuary technicians. A signed consent form by the next of kin must be obtained prior to autopsy along with a **brief clinical summary** for the Pathologist. Relatives must not be promised a specific time when a body will be released to them after an autopsy, as this is a matter to be arranged by the mortuary staff after the autopsy.

Please note that in the departments of Paediatrics and Obstetrics that doctors are asked to encourage parents who have lost their baby to have an autopsy for the benefit of the Confidential Enquiry into Stillbirths and Neonatal Deaths.

Informing the GP:

When a patient dies, one of the medical staff responsible for the patient (usually the House Officer) must inform the deceased's General Practitioner by telephone as soon as possible.

Dealing with stress:

It is not uncommon for doctors to feel stress after breaking bad news to a patient or being present at the death of a patient you know well. Stress may also occur due to long hours, guilt about a mistake, or break down in personal or professional relationships. It is important to share these feelings with your colleagues without delay, and counselling can be arranged if necessary. Again the confidential staff counselling service is available.

Phlebotomy service:

This service has been introduced to reduce the number of routine service tasks for the PRHO and other junior doctors. There is a daily service during the week and an **emergency service** over the weekend. **Please plan ahead:** write out the forms the night before and avoid doing any tests at the weekend unless absolutely necessary. Phlebotomists will only take venous blood samples from patients upon receipt of a properly completed laboratory request form.

Reports and Results:

All reports from Departments, X-ray reports, etc., must be promptly signed on arrival on the ward, and action taken as appropriate. Any abnormal results that return to the ward when you are on duty should be regarded as your responsibility: inform your colleagues and record the result in the case notes before going off duty. The filing of results is a shared responsibility depending on local arrangements.

General Guidelines:

From time to time there tends to be a lack of insight and, indeed, occasionally a lack of discipline by Medical Staff in the use of the Laboratory Services. The following strict guidelines are detailed below and they should be rigidly adhered to when sending specimens to the Laboratory for investigations.

Routine work:

The Laboratory at Altnagelvin provides a routine service from Monday to Friday between the hours of 9.00 a.m., and 5.15 p.m.

From Monday to Friday the bulk of routine specimens should normally be taken as early as possible in the day, preferably by 11.00 a.m., and certainly submitted to the Laboratory no later than 2.00 p.m. The Laboratory is unable to cope with large numbers of routine requests arriving in batches late in the afternoon as these have to be booked in and if they are specimens of blood they have to be separated before

being further processed. In some cases where routine specimens arrive too late in the afternoon to be processed it may be necessary to return the samples, as they would be too old for accurate analysis if kept until the following day. Such specimens will strictly not be dealt with during the out-of-hours service.

On-call Services:

The on-call service is provided at great financial cost and strictly urgent tests only should be requested during this period. Unreasonable requests submitted during on-call periods may have to be justified to the Consultant Pathologist the following day. Please avoid requesting tests to be carried out for example at eight o'clock in the morning during the on-call period if they can really wait until 9.00 a.m. On Saturday and Sunday mornings specimens thought to be necessary should reach the Laboratory not later than 11.00 a.m.

Correct labelling and identification of specimens:

One of the simplest levels at which disastrous mistakes can be made is in the labelling of specimens. It is your responsibility to ensure accurate labelling of specimens, even in the event of an emergency. This is particularly important for blood grouping, where you should confirm the patient's name and date of birth and hospital number with the patient and label the bottle at the bedside.

The patients name, hospital number, ward and Consultant must appear on both specimens and request forms. The Laboratory will not accept specimens that are inadequately or incorrectly labelled. The following details are mandatory: -

(1) Patient's name
(2) Hospital number
(3) Ward
(4) Consultant

If specimens and request forms are deemed to be inadequately detailed then the specimens will be returned to the Ward/Theatre/or Clinic.

Frozen sections:

Please arrange these directly with the Consultant Pathologist on the day before surgery if possible. Inform the Pathologist should the frozen section be cancelled or if there is going to be any significant delay.

Radiology[17]

It is important to read the current edition of the Royal College of Radiologists booklet "Making the best use of a department of Clinical Radiology"[17]. Appropriate use of radiology services will reduce radiation exposure for your patients. Pre-operative and pre-angiographic chest x-rays are not routine and should only be requested where there is a clinical indication (see RCR booklet[9]).

With regard to any investigation or procedure ask yourself the following questions:

- Do I need it?
- Do I need it NOW?
- Has it been done already?
- Have I explained the clinical problem?
- Have I asked for the best study?

Staff are encouraged to discuss clinical problems with the radiologist. Before you do so, be conversant with the history and examination and differential diagnosis and know why the procedure is needed. Don't be afraid to ask advice. Please also remember to update the clinical information on request forms as the clinical picture evolves.

Out of Hours Radiology service:

Urgent requests to radiographers should be made by bleeping the radiographer on call. Hand written forms should be backed up by a computer generated form. **Emergency requests made through the computer system out of hours will not alert the radiographer.** Requests for portable radiographs must only be made where it is impossible to bring the patient to the radiology department.

Use of ORDERCOMS:

You will receive training in the use of the computer system. Emergency requests should be made in consultation with the consultant radiologist. If you are looking for a radiology or laboratory report, most can be accessed through your ward's computer as soon as the result is available. Please check the computer before calling the office for results.

Our Mission

We will strive for excellence in the provision of diagnosis, care and treatment of patients, in a professional setting with compassion and kindness.

In pursuit of these aims we shall:

as a priority, heed the needs of;

- our patients
- our patients' relatives
- our staff,
- our purchasers,

strive to develop appropriate services;

- in creative ways,
- in responsive ways
- in effective ways
- in efficient ways

strive to develop constructive relationships;

- among staff,
- between professions,
- across the patient/provider/purchaser spectrum,

strive to;

- create a pleasant physical environment for patients, relatives and staff,
- create a supportive working environment,
- look continually to professional and human development needs amongst all staff.

INDEX REFERENCES

Essential Reading

The New Doctor (GMC) - for all PRHOs

Good Medical Practice (GMC) – for all Doctors

Maintaining Good Medical Practice (GMC) – for all Doctors

The Doctor as Teacher (GMC) – for all Doctors

Guidance on Consent (BMA) – for all Doctors

British National Formulary - for all Doctors

Text References

[1] 'Good Medical Practice' Guidelines from the GMC

[2] Procedures for doctors to report concerns about the Conduct, Performance or health of Medical Colleagues

[3] Trust policy on Protection of Patient and Client Information Altnagelvin HSS Trust, 2000.

[4] Disciplinary Procedures for Medical and Dental Staff Altnagelvin HSS Trust, 1999.

[5] Clinical Audit Strategy

[6] Study Leave Guidelines: NI Council For Postgraduate Medical And Dental Education

This document may be obtained from the Postgraduate Clinical Tutor or the Medical Personnel Office.

[7] Major Emergency Plan (pages 8, 13 to 15). Altnagelvin HSS Trust, 2000.

[8] Patients Case notes Standards

[9] Oncology: Information and guidelines for junior doctors, Altnagelvin Cancer Unit, 2000.

[10] Accident and Emergency Department handbook

[11] Control and Administration of Medicines

[12] Hospital Formulary

[13] Regulations and guidelines for the safe administration of blood and blood products (Altnagelvin)

[14] "Do not Resuscitate" policy

[15A] Guidelines for the retention of tissues and organs at post-mortem examinations (Royal College of Pathologists, March 2000)

[15B] Organ Retention: Interim guidance on post-mortem examination (CMO, March 2000)

[16] Laboratory services Handbook

[17] "Making The Best Use Of A Department Of Clinical Radiology" Royal College of Radiologists booklet

[18] Procedure for handling complaints (Altnagelvin HSS Trust, 1998)

General: Health and Safety Policy. Altnagelvin HSS Trust, 2000.
ICU admission policy

BMA booklet on Consent

DoH Reference Guide to Consent for Examination and treatment

Appendix A: Notifiable diseases

List of notifiable diseases

Acute Encephalitis	Marburg Disease	Smallpox
Acute Meningitis	Measles	Tuberculosis (Pulmonary and Non-Pulmonary)
Anthrax	Mumps	Typhoid Fever
Cholera	Paratyphoid Fever	Typhus
Diphtheria	Plague	Viral Haemorrhagic Fever
Dysentery	Poliomyelitis (Paralytic and Non-Paralytic)	Yellow Fever
Food Poisoning (ALL sources)	Rabies	
Gastroenteritis (persons under 2 years of age only)	Rubella	
Infectious Hepatitis	Relapsing Fever	
Lassa Fever	Scarlet Fever	

A.I.D.S. and Legionnaires diseases should be notified in confidence to the Director of Public Health or the Consultant in Communicable Diseases.

Appendix B: Useful Contacts

Chief Executive	Mrs Stella Burnside
Chairman of Trust	Mr Gerry Guckian
Medical Director	Dr Geoff Nesbitt
Director of Personnel	[redacted]
Director of Medical Education	Dr Frank O'Connor
Postgraduate Clinical Tutor	Dr Neil Corrigan
Postgraduate Secretary	[redacted]
Medical Education Services Manager	[redacted]
Study Leave Secretary	
PRHO Co-ordinator	
Medical Audit Officer	
Medical Audit Assistant	
Medical Personnel Manager	
Medical Personnel Officer	
College Tutors / Specialty advisors	
Medicine	Dr Heather Dunn
Surgery	Mr Robert Gilliland
Paediatrics	Dr Neil Corrigan
Orthopaedics	[redacted]
Ophthalmology	
ENT	
Obs & Gynae	Dr Paul McSorley
Anaesthetics	
Educational Co-ordinators	
Surgery	Mr S Dace
Undergraduate Tutors	
Medicine	Dr W. Dickey
Surgery	Mr R. Gilliland
Pathology	[redacted]
Paediatrics	Dr C Imrie
Orthopaedics	[redacted]
Obs & Gynae	

Patient's Advocate	Mrs Anne Doherty
Accommodation Officer	[redacted]
Private Patient's Officer	
Resuscitation Training Officer	
Infection Control Officer	
Trust Data Guardian	Mrs Marie Dunne
Risk Management Director	Mrs Theresa Brown
Occupational Health Physician	[redacted]
CARDIAC ARREST	

Appendix C: Royal College of Physicians of London Guidelines on Effective Patient Handover for Physicians.

Time:

- Fixed, known to medical/paramedical staff (urgent bleeps only)
- Adequate overlap of shifts/rotas
- Recognition should be made by the Trust of the time which is already used for handover
- 10-30 minutes should be allocated for handover, depending on the number and complexity of patients. Where bedside review is required, more time may be necessary.

Place

- Fixed, known to medical/paramedical staff

Cross Cover

- Inpatients who are unstable or who require review should be notified to the covering doctor, preferably in the form of a written list.
- Notification should normally be at a level e.g. SHO to SHO
- Inpatients who require review before discharge should be notified to the on call registrar
- Planned discharges may proceed provided the patient is stable.
- Important changes in status or management should be notified by the covering doctor at the end of the cover period.
- It should be clear to whom the on call doctor refers in the case of an emergency

Admission ward.

- Where patients are triaged to other wards and teams, responsibility lies with the admitting doctor to ensure that the other team is aware of review and urgent investigations required

Phone handover

- May be required in certain circumstances e.g. where emergencies preclude face to face handover

Notes:

ALTNAGELVIN CHILDREN'S UNIT DAILY FLUID CHART

DATE : .....

DIET : .....

Affix Label Here or Enter
NAME:
DOB:
UNIT NUMBER:

WARD:
CONSULTANT:

WEIGHT: .....kg

	ORAL/ENTERAL		INTRAVENOUS 1					INTRAVENOUS 2					OUTPUT					BM	COMMENTS	Signature
TIME	Amt.	Type	Amt/hr	Type	Total	IV Site 1	P	Amt/hr	Type	Total	IV Site 2	P	Urine	Faeces	Aspirate	Vomit	Drain			
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0900																				
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DAILY TOTALS

Intravenous Total	
Oral Total	
TOTAL INTAKE:	

Urine	Faeces	Aspirate	Vomit	Drain
TOTAL OUTPUT:				

IV Site Key:
0 – No Pain, no erythema
1 – Pain, no erythema
2 – Pain, erythema, swelling

RECOMMENDED DAILY FLUID REQUIREMENTS: mls

ALTNAGELVIN CHILDREN'S UNIT DAILY FLUID CHART

DATE : .....

DIET : .....

Affix Label Here or Enter
NAME:
DOB:
UNIT NUMBER:

WARD:
CONSULTANT:

WEIGHT: .....kg

	ORAL/ENTERAL		INTRAVENOUS 1					INTRAVENOUS 2					OUTPUT					BM	COMMENTS	Signature
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DAILY TOTALS

Intravenous Total	
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0 – No Pain, no erythema
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RECOMMENDED DAILY FLUID REQUIREMENTS: mls

any CHILD is AT RISK OF HYPONATRAEMIA

INTRODUCTION

- **Any child on IV fluids or oral rehydration is potentially at risk of hyponatraemia.**

- Hyponatraemia is potentially extremely serious, a rapid fall in sodium leading to cerebral oedema, seizures and death. Warning signs of hyponatraemia may be non-specific and include nausea, malaise and headache.

- Hyponatraemia most often reflects failure to excrete water. Stress, pain and nausea are all potent stimulators of anti-diuretic hormone (ADH), which inhibits water excretion.

- Complications of hyponatraemia most often occur due to the administration of excess or inappropriate fluid to a sick child, usually intravenously.

- Hyponatraemia may also occur in a child receiving excess or inappropriate oral rehydration fluids.

- Hyponatraemia can occur in a variety of clinical situations, even in a child who is not overtly "sick". Particular risks include:

  - Post-operative patients
  - CNS injuries
  - Bronchiolitis
  - Burns
  - Vomiting

BASELINE ASSESSMENT

Before starting IV fluids, the following must be measured and recorded:

- **Weight:** accurately in kg. [In a bed-bound child use best estimate.] Plot on centile chart or refer to normal range.

- **U&E:** take serum sodium into consideration.

FLUID REQUIREMENTS

Fluid needs should be assessed by a doctor competent in determining a child's fluid requirement. Accurate calculation is essential and includes:

Maintenance Fluid

- 100mls/kg for first 10kg body wt, plus
- 50mls/kg for the next 10kg, plus
- 20mls/kg for each kg thereafter, up to max of 70kg [This provides the total 24 hr calculation; divide by 24 to get the mls/hr].

Replacement Fluid

- Must always be considered and prescribed separately.
- Must reflect fluid loss in both volume and composition (lab analysis of the sodium content of fluid loss may be helpful).

CHOICE OF FLUID

- **Maintenance fluids** must in all instances be dictated by the anticipated sodium and potassium requirements. The glucose requirements, particularly of very young children, must also be met.

- **Replacement fluids** must reflect fluid lost. In most situations this implies a minimum sodium content of 130mmol/l.

- **When resuscitating** a child with clinical signs of shock, if a decision is made to administer a crystalloid, normal (0.9%) saline is an appropriate choice, while awaiting the serum sodium.

- The composition of oral rehydration fluids should also be carefully considered in light of the U&E analysis.

Hyponatraemia may occur in any child receiving any IV fluids or oral rehydration. Vigilance is needed for all children receiving fluids.

MONITOR

- **Clinical state:** including hydrational status. Pain, vomiting and general well-being should be documented.

- **Fluid balance:** must be assessed at least every 12 hours by an experienced member of clinical staff.

  Intake: All oral fluids (including medicines) must be recorded and IV intake reduced by equivalent amount.

  Output: Measure and record all losses (urine, vomiting, diarrhoea, etc.) as accurately as possible.

  If a child still needs prescribed fluids after 12 hours of starting, their requirements should be reassessed by a senior member of medical staff.

- **Biochemistry:** Blood sampling for U&E is essential at least once a day - more often if there are significant fluid losses or if clinical course is not as expected.

  The rate at which sodium falls is as important as the plasma level. A sodium that falls quickly may be accompanied by rapid fluid shifts with major clinical consequences.

  Consider using an indwelling heparinised cannula to facilitate repeat U&Es.

  Do not take samples from the same limb as the IV infusion.

  Capillary samples are adequate if venous sampling is not practical.

  Urine osmolarity/sodium: Very useful in hyponatraemia. Compare to plasma osmolarity and consult a senior Paediatrician or a Chemical Pathologist in interpreting results.

SEEK ADVICE

Advice and clinical input should be obtained from a senior member of medical staff, for example a Consultant Paediatrician, Consultant Anaesthetist or Consultant Chemical Pathologist

- In the event of problems that cannot be resolved locally, help should be sought from Consultant Paediatricians/ Anaesthetists at the PICU, RBHSC.

The Department Of Health, Social Services And Public Safety. Guidance is also available on the Departmental website : www.dhsspsni.gov.uk