Witness Statement Ref. No. 056/2

NAME OF CHILD: RAYCHEL FERGUSON

Name: E.T. Millar

Title: Ms

Present position and institution: Retired from NHS since November 2010.

Previous position and institution: Sister Ward 6 Altnagelvin Hospital
[As at the time of the child's death]

Membership of Advisory Panels and Committees: N/A
[Identify by date and title all of those since your witness statement dated 30th June 2005]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death since your witness statement dated 30th June 2005]

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

Ref:	Date:	
012-007-099	15.06.2001	Statement
012.041.202	05.02.2003	Deposition at the Inquest into the death of Raychel Ferguson
056/1	30.06.2005	Inquiry Witness Statement

IMPORTANT INSTRUCTIONS FOR ANSWERING:

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

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

I. QUERIES ARISING OUT OF YOUR INITIAL STATEMENT TO THE INQUIRY (WS-056/1)

(1) Arising out of the information you have provided about your career background (WS-056/1 Page 1)

(a) Describe your work commitments to the Altnagelvin Hospital from the date of your appointment as a Ward Sister in July 1986, stating the locations in which you worked and the periods of time in each department/location.

My work commitments in the Altnagelvin Hospital were:-

To carry continuing overall responsibility for the children's unit comprising of:

i. Ward 43 beds
ii. Day Care Unit
iii. Paediatric Out Patients Clinic
iv. Transitional Care Unit

To provide professional and clinical leadership to a multi-professional team and be an active member in taking children's services forward.

To act as advocate for children and their parents.
To liaise with other statutory and voluntary agencies on behalf of the children and their parents as appropriate.
To introduce evidence based holistic care to all areas of the children Unit.
To act in partnership with colleagues in the Neonatal Unit in planning training/rotation of staff to facilitate the discharge process of Technology Dependent babies/children.

The overall management of the Unit, deployment and management/supervision of staff, the teaching of basic and post basic learner and the development of trained staff.

Job Description 1989 + 2004 provided.
From my appointment as a ward sister in July 1986 to my retirement in November 2010, I worked on the Paediatric ward in Altnagelvin Hospital.

(b) Specify all those periods of time working as Ward Sister in Altnagelvin which related to the care and treatment of children.

All of my time working in Altnagelvin Hospital was in the care and treatment of children.

(c) Describe your duties as a Nursing Sister at Altnagelvin Hospital on the 8th June 2001.
Job description 1989 and 2004 G Grade I H Grade Band 8
Job Description and 2004 H Grade
Initial Job Description as G Grade in 1989 developed and evolved over the years with increasing responsibilities and accountability.

(2) At the time of your appointment to Altnagelvin Hospital as a Ward Sister were you provided with training or induction and if so,

(a) Describe the training or induction which you received.
No formal induction or training received. Before working in Altnagelvin, I had "acted" as Sister from October 1985 to July 1986 and had been senior staff nurse for 8 years working alongside the sister at that time and had taken charge in her absence. Also had 4 and half years experience as Staff Nurse in Royal Belfast Hospital for Sick Children and had a ward sisters post there from September 1974 - August 1976.

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

Management course (2 weeks) attended at the Beeches Management Centre in Belfast this may have being in 1986 or 1987. (November).
Course was mainly regarding management of staff, finance, health and safety, regarding fire and safety of equipment were also covered.

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

Cannot recall who delivered training at the course.

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

Documentation was received including certificate of completion of the course but I do not have them now.

On retiring in November 2010, I did not keep any documentation etc. related to training throughout my career.

(3) You have identified in your witness statement all of the training which you have received between September 1994 and June 2005: (WS-056/1 Page 1). With regard to the training which you received before June 2001, did the content of the training cover any of the following issues:

(a) Fluid management in children, including the use of hypotonic fluids;
No.

(b) The management of post-operative vomiting and nausea;
No formal training - my knowledge was gained from experience over the years.

(c) Hyponatraemia;
No.

(d) Observations and record-keeping?
During student nurse training I did receive instruction on observations and record keeping. In training as a staff nurse, this knowledge was developed and practised continually over the years. No further formal training was received - gaining knowledge was always ongoing and on the job.

(4) *"Following the handover report I allocated the staff to their areas of the ward and delegated to them their duties."* (WS-056/1 page 3)

(a) Which nursing staff did you allocate to the care of Raychel?
Staff Nurse Michaela Rice McAuley & Staff Nurse Avril Roulston.
(Staff Nurse Roulston being the senior nurse)
Staff Nurse Roulston at some stage had also to 'cover' the Infant Area due to staff sickness, I think Staff Nurse McAuley was the main carer for Raychel that day. It was usual for all staff to get hand-over reports on all the patients as often due to business, sickness etc. they had to help in other areas.

(b) Did you provide those nursing staff allocated to the care of Raychel any particular instructions with regard to how she was to be cared for?

No. Raychel's condition, post op observations and anything else of importance would have been communicated to staff at the handover. As Raychel's condition was reported as stable, specific instructions were not added to that of ongoing post-operative care and observation.

(c) If so, please specify what those instructions were.
None

(5) Arising out of Mr. Zafar's attendance with Raychel you have said the following:

"Mr. Zafar the Surgical SHO came and saw Raychel early morning. Mr. Zafar was happy for Raychel to have small amounts of clear fluids orally. The intravenous fluids were to continue as prescribed. Mr. Zafar spoke to Mr. Ferguson of his plan for Raychel. Dr. Makar also came to the ward to check on Raychel shortly afterwards. I explained to him that Mr. Zafar had already seen Raychel so he did not see Raychel but did speak to Mr. Ferguson. I was with Mr. Zafar when he saw Raychel but did not accompany Dr. Makar. Dr. Makar made no change to Raychel's treatment. I documented the plan for Raychel in the ward 'Treatment Book' which is referred to by staff during the day and also communicated verbally the plan to the nurses caring for Raychel." (WS-056/1 page 3)

(a) What time did Mr. Zafar see Raychel?
I cannot recall the exact time, but would have been between 8.30am and 10.00am.

(b) To the best of your knowledge is the timing of Mr. Zafar's attendance on Raychel recorded in any document?
No.

(c) What time did Dr. Makar see Raychel?
Dr Makar came shortly after Mr Zafar, both were in the ward at same time. Dr Makar did not examine Raychel as Mr Zafar had already seen her. As far as I can remember, Dr Makar had a brief conversation with Mr Ferguson.

(d) To the best of your knowledge is the timing of Dr. Makar's attendance on Raychel recorded in any document?
No. Mr Zafar had seen Raychel, Dr Makar did not formally see her, but had a brief conversation with Mr Ferguson.

(e) To the best of your knowledge did Dr. Makar make any clinical notes arising out of his attendance with Raychel?
No.

(f) Which doctor had responsibility for Raychel's care during the 8th June 2001?
Mr Gilliland.

(g) Were you told by either Mr. Zafar or Dr. Makar how long the intravenous fluids were to continue for?
As far as I can recall, we were not told any definite length of time. I understood that the fluids would continue until Raychel was taking adequate oral fluids and retaining them. Raychel had vomited at 8am so oral fluids were to be only 'sips' and slowly introduced.

(h) Was any measurement taken and recorded of the amount of clear fluids which Raychel took orally during the 8th June 2001? If so, please indicate how the measurement was taken and where it is recorded.
No record made. Raychel did get very small 'sips' of fluid orally but these were not measured.

(i) If no measurement and recording was made of the amount of clear fluids taken orally by Raychel during the 8th June 2001, please explain this omission?
This should have been documented and I can give no explanation.

(j) Was the fact that Raychel had vomited at 08.00 (Ref: 020-018-037) brought to the attention of either Mr. Zafar or Dr. Makar, and if so who brought it to their attention and what was their response?
I am sure I informed Mr Zafar of Raychel's 8am vomit; this would be usual practice to mention to the visiting surgeon of any untoward incidents. Also my documentation in the "treatment" communication Book states "allowed sips later", this would be in keeping with delaying the offering of oral fluids due to Raychel's 8am vomit. Also the IV fluids were left unchanged.
Mr Zafar would also have noted the 8am vomit on Raychel's fluid balance sheet. It was usual for the Doctor to look at this sheet. I do not recall having a conversation with Doctor Makar.

(k) If the vomit at 08.00 was not brought to the attention of Mr. Zafar or Dr. Makar, please explain why this was not done?
As far as I can recall the 8am vomit was brought to the attention of Mr Zafar.

(l) State precisely what you recorded in the ward '*Treatment Book*' and provide a copy of the relevant extract from that book, or otherwise identify the document from the materials which are available to the Inquiry.

"Allowed sips later, S/B Surgical Doctor, Analgesia, if drinking IV Fluids." (Photocopy Attached)

(m) Identify the nurses to whom you communicated the treatment plan regarding Raychel?

Staff nurse Michaela McAuley & Staff Nurse Avril Roulston. I would have verbally communicated the plan for Raychel, plus it was also communicated in the Treatment Book.

(n) State precisely what you told those nurses about the treatment plan for Raychel.

Raychel was allowed 'sips' later, (the "later" I recall was because she had vomited at 8am so oral fluids were not to be rushed.) Raychel had been seen by the surgical Doctor, Analgesia could be given as required 8 hourly. If Raychel was tolerating oral fluids later the IV fluids could be reduced and eventually discontinued.

(6) *"Raychel vomited at 10am, 1pm, and 3pm that day (See 020-018-038). I had noted this and it was also communicated to me by the nurses looking after Raychel. I was not concerned as vomiting is not unusual in some children postoperatively."* (WS-056/1 page 3)

(a) Can you be sure that every episode of Raychel's vomiting recorded on the fluid balance sheet (Ref: 020-018-037)? If you feel that you can be sure in this regard, please explain how you can be sure.

It is the practice to record all vomits. Also as paediatric nurses we work closely with parents and ask them to inform us of any vomits, passing of urine etc., that may occur when we are occupied with other patients or at meal breaks. Etc.

(b) You do not mention the vomit at 08.00 (Ref: 020-018-037) in your statement to the Inquiry at WS-056/1 page3. Did you take account of this vomit when reaching the view that there was no cause for concern in Raychel's case?
I did take account of Raychel's vomit at 8am, as it was documented on her fluid balance sheet by the night staff. Also, I am as certain as I can be that I brought it to Mr Zafar's attention, hence my documentation in the Treatment Book of "later."

(c) Were any steps taken to advise a doctor in relation to Raychel's vomiting at any time before 15.30-16.00? If not, please explain why steps were not taken to contact a doctor before this time?
Mr Zafar was aware of 8am vomit as far as I can recall.
During the medical ward round I was in Raychel's room at approximately 10 am - 11am and saw a vomit bowl on Raychel's bed table with vomit in it. I did not consider it to be a large amount even though it was documented as "large." I asked a nurse to dispose of it, I cannot recall who. I was not concerned that Raychel had vomited a second time as it was not in my opinion a large amount; it covered the bottom of the bowl. Also Raychel was on IV fluids so any loss of fluid by vomiting was being replaced. Raychel was bright, alert and happy so I had no concern. I cannot be 100% sure whether this vomit was at 8am or 10am, but on looking back I think it was the 10am.

(d) Were you advised of the actions, if any, that were taken by nursing staff when Raychel vomited? If so, please describe the actions taken by nursing staff when Raychel vomited at each of the following times:

(i) 08.00;
Mr Zafar was informed.

(ii) 10.00;
I was aware of documentation. I had seen the 10am vomit.
I was also in Raychel's Room several times during the morning, in addition to my early morning visit, and Mr Zafar's visit, I was also there for the Paediatric ward round and checking on the other patients.
Raychel's bed was also very visible from the nurses' station, so it was easy to observe what Raychel was doing and who was with her.

(iii) 13.00;
I was aware as a nurse informed me and I had seen documentation in fluid balance chart.

(iv) 15.00?
I was informed by Staff nurse McAuley, I was in my office on the other wing, she rang me and I asked her to contact the surgical doctor, this is my recollection.

It was usual for me to spend time each afternoon in my office. I had 4 areas of responsibility and had a large number of staff. This time was mostly taken up with managerial issues.
I was always available to staff anywhere if required. There were always senior members of staff on duty to take charge in my absence.

(e) Please clarify whether recordings ought to have been made of Raychel's vital signs following each episode of vomiting and if so,

Raychel was on 4 hourly observations. Raychel was bright and alert despite the vomits, she was giving no other cause for concern. It was not practice to undertake vital signs observations when children vomited unless their condition was ill or deteriorating or they were being specialed one to one.

(i) Clarify whether this was done in Raychel's case?
No

(ii) If it was not done following each episode, please explain why it wasn't done?
See (e) above

(iii) If it was done following each episode, were the findings noted, and if so where are they noted?
Not done. 4 hourly observations stable.

(iv) If the findings weren't noted following any episode, please explain why this wasn't done?
N/A

(f) Was Raychel's vomiting discussed with you at any time before 15.30-16.00 when you were approached by S/N McAuley? If so,

(i) Who discussed the vomiting with you?
After Mr Zafar saw Raychel, I communicated to staff nurse McAuley the plan, the 8am vomit was acknowledged during this communication.

(ii) What was discussed?
Cannot recall exactly, except to acknowledge that Raychel had vomited at 8am and 10am.

(iii) Did you provide any advice, instruction or guidance?
Would have done but cannot recall.

(iv) If so, describe the advice, instruction or guidance you gave?
Observe for any further vomits, not to push too much oral fluids, continue IV fluids. This is as far as I can recall.

(g) Was any attempt made to formally measure the volume of Raychel's vomiting? If not, please explain why this was not done?

Was not practice unless patient was ill, doctor had requested or patient was "specialed" one to one.

(h) Was any attempt made to measure Raychel's urinary output? If not, please explain why this was not done.

This was not common practice unless the patient was very ill, or was a renal patient, or the doctor had requested same, or the patient was being "specialed" by a nurse on a one to one basis.

(i) In June 2001 were you aware of the factors that could cause an electrolyte imbalance in a paediatric patient following surgery?
No.

(j) If so, please identify the factors that you were aware of that could cause an electrolyte imbalance in a paediatric patient following surgery?
N/A

(k) Were any of those factors present in Raychel's case?
At that time (2001), I was not aware of the factors that can cause electrolyte imbalance in a paediatric patient following surgery. However knowing now the factors since Raychel's death, I recognize that vomiting can be one of those factors.

(l) If you were aware of the factors that could cause an electrolyte imbalance in a paediatric patient following surgery, did you take them into account and consider them when you reached the view that there was no reason to be particularly concerned about Raychel? If so, what conclusions did you reach?
N/A

(7) *"At approximately 3.30pm-4.00pm S/N McAuley informed me of Raychel's vomit at 3.00pm. I asked Staff Nurse Michaela McAuley to contact the Surgical JHO or SHO to give Raychel some anti-emetic i.e. intravenous Zofan. There was difficulty contacting the surgical doctors as they were in theatre and did not answer their bleeps. Shortly afterwards Dr. Joe Devlin JHO came to the ward to clerk in a new patient. Dr. Devlin was asked to give Raychel an anti-emetic. He did this at approximately 6pm."* (WS-056/1 page 3)

(a) In 2001, what system was in place when nursing staff needed to obtain assistance from a doctor in relation to a paediatric surgical patient, and how did this system work?

"Bleep System" was in place for staff to contact surgical doctors or indeed any doctor within the different specialities. The "on-call doctor's rota" for surgery was available on the office notice board. This rota was renewed each month.

(b) In 2001, please explain how the "bleeper" system was supposed to work in Altnagelvin Hospital.

The switchboard was contacted by phone and asked to bleep doctor who in turn rang the ward when his bleep received the message. The system worked very well and during my years in Altnagelvin I did not experience many problems contacting Doctors via the system.

(c) What options were available to a nurse in circumstances where surgical staff were not answering their bleeps because they were in theatre, and nursing staff required assistance from a member of the surgical team?

My experience was that surgical doctors mostly answered their bleeps even if in Theatre. They either answered their bleep from Theatre or a Theatre member of staff answered for them took a message and relayed back any relevant message from the Doctors.

If a surgical doctor was in Theatre and said he would come to the ward following Theatre, that was often acceptable. However if a doctor was required urgently, the doctor in Theatre might advise who else was available. Also nurses often rang the adult surgical wards to ask for assistance, and the ward sisters or senior staff there were usually very helpful.

Where a surgical consultant was concerned in addition to the above, their secretary usually knew where they where, ie. in clinics, Theatre etc. If a surgical doctor was unavailable and was required urgently and all of the above failed, a Paediatric doctor would be asked for assistance.

(d) At what time were steps first taken to contact a surgical JHO or SHO?
Approximately 3pm or shortly afterwards.

(e) Identify by name those doctors which S/N McAuley attempt to make contact with only to find that they were in theatre?

Cannot recall but thought it would have been Mr Zafar or Dr Makar.

(f) How do you know that those doctors were in theatre?
When doctors were bleeped, they either answered directly themselves, or Theatre staff answered for them to say they were in Theatre.

(g) What were the reasons for deciding to contact a member of the surgical team at 15.30-16.00?
Because of Raychel's vomiting which was not settling.

(h) Were any other options considered when S/N McAuley experienced a difficulty in contacting a member of the surgical team?
No, understood that the doctors contacted said they would come when they finished in Theatre. Despite the vomits Raychel had, she was not giving any other cause for concern.

(i) What consideration, if any, was given to requesting a more senior member of the surgical team than a JHO or SHO to examine Raychel and to review her condition?
None.

(j) Was paediatric medical advice and assistance available upon request to the nursing staff caring for surgical patients on Ward 6?
Yes.

If so, please address the following:

(i) How was a nurse expected to make a request?
Direct request.

(ii) To whom was a request to be directed?
Whatever Paediatric doctor was on the ward, SHO Registrar or Consultant. If no paediatrician doctor was on the ward he/she could be bleeped.

(iii) On what matters could paediatric medical advice or assistance be requested by a nurse?
Any matter at all, Paediatric doctors always available when /if required.

(iv) How were you informed of the arrangement by which you could make a request for paediatric medical advice or assistance?
It was a known practice on the ward. All senior nurses and indeed most junior nurses were aware of this. Surgical doctors were frequently asked for opinions in paediatric surgical patients.

(v) During the morning or afternoon of the 8th June 2001 when Raychel was continuing to vomit, was a member of the paediatric medical team on duty at or near the Ward 6?
Yes.

(vi) On the morning or afternoon of the 8th June 2001 would it have been possible to contact a member of the paediatric medical team to examine Raychel?
Yes.

(vii) On the morning or afternoon of the 8th June 2001, what consideration, if any, was given by you or others to asking a member of the paediatric medical team to examine Raychel?
None.

(viii) If no consideration was given to making a request for paediatric input in Raychel's case, please explain the reasons for this?
Raychel was not giving any cause for concern except for her vomiting which had not settled. Raychel's vital signs were stable and it was felt that there was no great urgency in getting the surgical doctor as it was understood he/she would come soon from Theatre. Also Raychel had IV fluids in situ and it was hoped that the administration of IV emetic would settle her vomiting.

(k) What was Raychel's condition in the period from 15.00 when she vomited, and 18.00 when Dr. Devlin administered an anti-emetic?
Raychel's condition was stable, her observations were stable and the nurses did not have any concerns except for her vomiting. I was in my office on the other wing of the 6th floor from approximately 2.30pm - 4.30pm so did not see Raychel during this period. I was informed of the 3pm vomit by telephone from the ward by Staff nurse McAuley.
I returned to Ward 6 at approximately 4.30pm-5pm.
I noted that Raychel had visitors at her bedside, she appeared to be sleeping. This would have been not unusual as she had very little rest or sleep since early morning.

(l) Did Raychel vomit in the period between 15.00 and 18.00?

No. Not aware of any further episodes as no recording was made on fluid balance sheet, by nursing staff. It was the practice to record all vomits and parents would also inform us if a patient had vomited.

(m) If she did vomit in this period was the vomiting noted and recorded? Please explain any omission to note and record the vomit.
No vomits.

(n) Who asked Dr. Devlin to give Raychel an anti-emetic?
As far as I can recall, staff nurse McAuley.

(o) Why was Dr. Devlin asked to give Raychel an anti-emetic?
Doctor Devlin was asked to give anti-emetic as the other doctors had not as yet come from Theatre.

(p) Please explain what consideration, if any, was given to asking a doctor to prescribe an anti-emetic at any time before the late afternoon of the 8th June 2001, in circumstances where Raychel's vomiting had commenced at 08.00?
At 3pm approximately, surgical doctors were contacted to see Raychel, and give IV anti-emetic. Raychel had again vomited at this time and it was becoming apparent that her vomiting was not settling as hoped. The earlier vomits were noted and documented and these vomits were deemed to be not of a large volume despite one of them (10am) being noted as large. Raychel's condition was stable; she had IV fluids in situ and was showing no other signs of concern.

(q) What notes or records, if any, were made in relation to the attempts to contact a JHO, the attendance of Dr. Devlin and the steps taken by him? Please explain any omission to make a note or record in relation to any of these matters.
No records or notes made, I have no explanation for this.

(r) Can you explain why the time at which the anti-emetic administered was not recorded in Raychel's notes?
No explanation.

(s) Would it have been your expectation that the administration of the anti-emetic should have been recorded in a clinical or nursing note? If so, what information would you have expected that note to have contained?
Recording should have been made.
Recording should have included:-
Name of drug administered
Reason for administration
Amount of Drug given
Route by which drug given
Also written on prescription sheet
Signature of Doctor

(t) Did you have any dealings with Dr. Devlin when he attended on Raychel? If so,
No.

(i) What did you discuss?
N/A.

(ii) Did you tell him anything about Raychel's history and condition, and if so what did you tell him?
N/A.

(iii) Did you provide him with any notes or records in relation to Raychel, and if so what did you provide him with?
N/A.

(iv) Did he make any note or record relating to his attendance on Raychel, apart from the drug entry at Ref: 020-017-035?
N/A.

(v) Did you or any member of nursing staff make any note or record in relation to his attendance on Raychel?
I did not make any note as I did not speak with Doctor Devlin. I had gone off-duty or was going at that stage.

(vi) Did he examine Raychel? If so, what form did that examination take?
N/A.

(vii) Did he take a history from Raychel or her mother or father?
N/A.

(viii) Were you or any member of nursing staff given any directions by Dr. Devlin following the administration of the anti-emetic?
N/A.

(ix) Did you make any request or make any suggestion to Dr. Devlin in relation to Raychel's condition and treatment?
No. N/A.

(8) *" I went off duty at approximately 6pm. I had no concerns with regards Raychel's condition. I expected Raychel's vomiting to settle following the administration of intravenous Zofan (020-017-035). I expected her intravenous fluids to be discontinued the next day and for her to be discharged possibly on Sunday."* (WS-056/1 page 3)

(a) At any time before going off duty did you give any consideration to whether the conditions existed which placed Raychel at risk of suffering an electrolyte imbalance?
No.

(b) If you did give consideration to the risk of an electrolyte imbalance in Raychel's case, what conclusions did you reach?
N/A.

(c) At what time did you last see Raychel before going off duty?
Cannot recall exactly but sometime between 5-6pm

(d) Describe Raychel's condition when you last saw her before going off duty?
I noted Raychel was sleeping as I was going off duty. Doctor Devlin was on the ward and had been asked by staff nurse McAuley to give Raychel IV anti-emetic. I had suggested to staff nurse McAuley to ask Doctor Devlin. Raychel's observations were stable.

(e) At what time did you last receive a report in relation to Raychel before going off duty?

I did not receive any formal report on Raychel before going off duty. I had been in my office from approximately 2.30 - 4.30pm as had been my practice. I had kept in touch with staff nurse McAuley since her phone call to me at approximately 3pm. I had checked with her as to whether she had been able to contact the surgical doctors.

I usually spent time each afternoon in my office ie. 2-5pm catching up on nurse rotas, seeing staff or attending meetings etc. I usually returned to the ward approximately 5-5.30pm before going off duty. My finishing time was 5.30pm. The staff left on duty finished their shift at 8pm.

(f) Who provided you with the last report in relation to Raychel before you went off duty, and what were you told in relation to her condition?
I would have had an informal discussion with staff nurse McAuley before going off duty, confirming that Doctor Devlin would administer IV anti-emetic and confirming that there were no further concerns regarding Raychel. This is to the best of my recollection.

(g) When you went off duty did you participate in a hand-over?
No.

(h) Who did you hand-over to?
Cannot recall. Main hand overs were at 7.45am, and 8pm. Mini-handover at Lunchtime.

(i) Was Raychel' condition and treatment discussed during the hand-over, and if so, what information did you or other nursing staff convey to those who were coming on duty?
No handover at 5.30pm. Handover at 8pm.

(j) When going off duty, did you leave any instructions with regard to the continued monitoring of Raychel?
No.

(k) If so, who did you leave those instructions with?
N/A.

(l) What instructions did you give with regard to continued monitoring of Raychel?
None. Nurses caring for Raychel were aware of the care Raychel should continue to receive.

(m) What steps would you have expected nursing staff to have taken if Raychel's vomiting did not settle following the administration of intravenous Zofan?
Surgical doctor should be contacted and asked to review Raychel.

(9) *"3. Approximately between 9.30am and 10am I was in Room I doing the ward round with the medical doctor (there were two medical patients in Room I). I noticed a vomit basin on Raychel's bed table with a small amount of vomit in it (just covering the bottom of the bowl). I understood this to be the vomit as from 8am that morning and it had not been removed and discarded. I cannot remember if I removed it or gave it to one of the nurses to discard. Mr. Ferguson did not make any comment to me. I thought perhaps Mr. Ferguson might be concerned that Raychel had vomited and was hesitant to make his concerns known to me. I reassured Mr. Ferguson and reiterated what I had said earlier..."* (WS-056/1 page 4)

(a) Did you ask Mr. Ferguson to explain when Raychel had suffered the vomit you saw in the vomit basin when you were in Room I between 09.30 and 10.00?
Cannot recall.

(b) Would you have expected your nursing staff to have removed any vomit basin relating to the 08.00 episode of vomiting when they recorded Raychel's observations at 09.00?
Yes.

(c) Did you give Mr. Ferguson any instructions with regard to the importance of reporting episodes of vomiting to nursing staff?
Cannot recall but did give explanation and reassurance. I remember this very clearly. I had several conversations with Mr Ferguson from early morning to approximately 1.30pm when I went to Lunch.

(d) To the best of your knowledge, during the 8 June 2001 describe the nature and extent of any communication between you or your nursing staff and either Mr. or Mrs. Ferguson and clarify,

(i) Whether either parent raised any concern about Raychel's condition, and if so what was said?

Not aware of any concerns raised by either parent. I do not remember seeing Mrs. Ferguson in the ward from approximately 9am to late afternoon. I presumed she had gone home to rest. I did see her at Raychel's bedside before I went off duty at approximately 5.30 - 6pm.

(ii) If either parent did raise any concern about Raychel's condition, what response was given by nursing staff?
Not aware of any concerns regarding Raychel's conditions.

(iii) Whether either parent raised any concern about Raychel's treatment, and if so what was said?
Not aware of any concern's regarding Raychel's treatment.

(iv) If either parent did raise any concern about Raychel's treatment, what response was given by nursing staff?
N/A.

(v) Whether any parental expression of concern about Raychel's condition or treatment was recorded by you or your nursing team, and if so where is it recorded?
No concerns raised either to me or my nursing staff during my time on duty 7.30am - approximately 6pm.

(10) *"In Altnagelvin Hartmann's Solution may be given intraoperatively but on return to the ward intravenous fluids were continued as Solution 18. The intravenous fluid was continued as prescribed prior to Theatre or the Surgical doctor was asked to re-prescribe the fluid."* (WS-056/1 page 5)

(a) In 2001 were the arrangements for post-operative fluid management the subject of a written protocol or guidance? If so, please identify the document.
No written protocols or guidance.

(b) If post-operative fluid management was not the subject of a written protocol or guidance in 2001, was it otherwise the subject of an unwritten protocol or guidance? If so, how was this expressed?
Solution 18 had been the preferred choice of fluid for children for as long as I can recall. During my time in the Royal Belfast Hospital for Sick Children, IV Solution 18 was also the preferred solution.

(c) In any event, how were the arrangements for post-operative fluid management communicated to nursing and medical staff?
Written practice that Solution 18 was the default Solution to be used for all children.

(d) Do you know why a new prescription for fluids was not written for Raychel after she returned to the ward following surgery?
Custom and practice to continue the pre-op prescription.

(e) Would it have been practice in 2001 to have written a new prescription for post-operative fluids?
Not unless the pre-op fluids were completed. Eg. 1 litre prescribed and all of 1 litre had been infused pre-operatively.

(f) By 2001, did you understand the rationale for the practice of continuing post-operatively the fluids which had been prescribed pre-operatively?
I understood we continued the same post-op fluids which had been prescribed pre-operatively as child was unable to tolerate oral fluids immediately post-op.

(g) In 2001, in what circumstances would the surgical doctor have been asked to re-prescribe fluids on return to the ward, rather than continuing with the fluids prescribed pre-operatively?
Surgical doctor asked to prescribe fluids if initial prescription was complete or IV Bag had been discarded for some reason.

(h) What is your understanding of how decisions were reached with regard to the fluid management of Raychel post operatively?
The IV fluids administered to Raychel were in keeping with the practice at the time.

(i) In particular identify the person(s) who were responsible for making the decision that Raychel should continue (post-operatively) to receive Solution 18 at a rate of 80 ml/hr.?
I do not recall.

(j) What is your understanding of the reasons for maintaining Raychel on the same fluid rate (80ml/hr) after surgery as was applicable before surgery?

Rate not changed as Raychel was being introduced to small amounts of oral fluids. Once established, rate would be reduced.

(k) At any time did you check the fluid rate which had been prescribed for Raychel, and if so, did you give any consideration to whether it was an appropriate rate?
No. The Doctor prescribed the IV fluid and the rate of fluid to the patient.

(l) In 2001 was there any arrangements in place on Ward 6 to review the continued appropriateness of the fluid prescription for a post-operative patient? If so, describe those arrangements.
No.

(m) If there was no arrangements in place, what steps would have to be taken before fluid management for a patient could be changed?
N/A.

(n) In 2001 what was your understanding of the appropriateness of using Solution 18 as a fluid in circumstances where there were gastric losses, or as a replacement for those losses?
Solution 18 was preferred solution for all children.

(o) What is your current understanding of the appropriateness of using Solution 18 in circumstances where the patient is suffering gastric losses?

Although I retired I am aware that Solution 18 is no longer used in general paediatrics.

(11) "A meeting with the Ferguson family (022-084-215 - 022-084-224) took place on the 3 September 2001 at 6pm in the Clinical Education Centre. I attended the meeting and found it extremely difficult. I had not attended a meeting similar to it before, the atmosphere was understandably tense and I felt I was not able to give the family the reassurance and explanations that I would have wished. I did try to explain that at no time during my time on duty did I think Raychel's condition was given cause for concern; I had experienced post operative children vomiting many times and was at a loss to explain Raychel's sudden deterioration." (WS-056/1 page 7)

(a) Why were you unable to give the Ferguson family the reassurances and explanations you would have wished?
As said in my statement, I found the meeting with the Ferguson family very difficult. The atmosphere was understandably tense and I was not sure of the part I was expected to take. Mrs. Burnside and Doctor Nesbitt led the meeting as far as I can remember. Mrs. Ferguson was beyond grief. Doctor Nesbitt did his best to explain to the family as to what had happened to Raychel, but I do not think that Mrs. Ferguson was capable of understanding much of what was said as she was so distraught.

Doctor Nesbitt was very sympathetic and apologetic and I believe did his very best to give a clear and concise explanation to the Ferguson family.

I personally felt that any intervention from me would not have helped. I did not want to add to Mrs Ferguson's distress. On a personal level I was very distressed for the family. I was trembling following the meeting as I felt it was one of the most difficult situations I had been involved in. I remember Mrs Burnside or Doctor Nesbitt apologizing to the family for what had happened to Raychel.

(b) State precisely the reassurances and explanations you would have wished to have given the Ferguson family?

I would have said that on the day following Raychel's surgery (8th) there were no concerns on behalf of the nursing staff that would have given us any indication as to Raychel's sudden deterioration. Raychel did have a number of vomits, but this was not unusual in some patients following surgery, Raychel's observations were stable, she had IV fluids in situ I understand from staff she appeared bright and alert up until she slept in the later afternoon. Again this was not of concern as Raychel had been awake most of the day since early morning despite her surgery being late on the 7th June. Raychel had also walked twice to the bathroom with Mr Ferguson during lunchtime hours, which was a positive sign. It was expected that Raychel's vomiting would settle, oral fluids established and Raychel's IV fluids decreased or discontinued.
It was a total shock to hear of Raychel's death when I returned to duty on Tuesday June 12th. I would never have expected Raychel to deteriorate as she did, having had input into her care on the day following her surgery. I had not experienced or known of any similar case in all my years of nursing sick children.

(c) Provide full details of any subsequent attempt to give the Ferguson family the reassurances and explanations you would have wished?

I did not have any further contact with the Ferguson family.

(d) If you did not make any subsequent attempt to provide reassurances/explanations, please explain why you did not seek out that opportunity?

Was aware that the Hospital Management / Trust were in contact with the family and did not think my input would be of any further help to the information already given to the family.

(e) Are you now aware of the reasons for Raychel's "sudden deterioration"?
Yes.

(12) *"During my long career (35 yrs) in caring for sick children I have not seen or been aware of Hyponatraemia in Post-operative surgical children. I have nursed many children over the years following surgery, and have not seen a child either become ill or die with this condition."* (WS-056/1 page 7)

(a) In 2001 were you aware of the factors which, if present, could present a risk of causing hyponatraemia in post-surgical children?

No.

(b) If so, outline what you understood those factors to be?
N/A.

(c) If you were aware of those factors in 2001, did you give any consideration to whether they existed in Raychel's case at the time when she was being nursed on Ward 6?
N/A.

(d) If you did give consideration to whether those factors existed in Raychel's case, what conclusions did you reach?
N/A.

(e) If you did not give consideration to whether those factors existed in Raychel's case, please explain your omission to do so?
N/A.

II. QUERIES ARISING OUT OF YOUR DEPOSITION TO THE CORONER DATED 5 FEBRUARY 2003

(13) You have been recorded as telling the Coroner, *"I would not agree that Raychel was listless that day."* (Ref: 012-041-204).

However, in a solicitor's note made in relation to your evidence the following is recorded: *"It was further put to her that Mrs. Ferguson had thought the child was unwell during the period the Sister had no concerns, the Sister said she would be prepared to agree with the description of Raychel as being listless."* (Ref: 098-018-044).

(a) Please clarify whether you do accept that Raychel could be accurately described as having been *"listless"* during the 8 June 2001.

I do not accept that Raychel could be described as "listless" on June 8th. During my giving evidence to the Coronors Inquest on February 5th 2003 it was put to me by the family's solicitor that Mrs Ferguson thought that Raychel was unwell druing the day of the 8th June, my response that I would be prepared to agree with Mrs Ferguson's description of Raychel as "listless" was said because I believe that parents often know their children best and it would have been wrong of me to disagree with Mrs. Ferguson. However, I am firmly of the belief that Raychel did not display signs of listlessness during my time on duty.

(b) If you do accept that she could be accurately described as having been *"listless"* on that day, state the time or the period when that descriptor would have been applicable.
See above.

(c) What were the indicators of listlessness in Raychel's case?
See above.

III. QUERIES RELATING TO RECORD KEEPING

(14) Explain why 'nausea' and 'vomiting' were not identified as potential or actual nursing problems in the episodic care plan for Raychel (Ref: 020-027-056 to Ref: 020-027-065)?
No explanation.

(15) In terms of the care plan that had been formulated for Raychel:

(a) Was the care plan available at the bedside, and if not, how was it accessed?
Care plan not available at bedside. All care plans available and accessed by nursing staff in Sisters office/Nursing Station. This was the practice at that time.

(b) During the period when you were on duty what arrangements were in place for evaluating the care provided under the care plan and state,

(i) How was this task performed?

Performed using a computer software package known as DM Nurse.

(ii) Who was responsible for evaluating the care provided under the care plan?
The nurse/nursing staff allocated to the area the patient was being cared for on their shift. (4 areas within Ward 6).

(iii) At what time, or in relation to what events, was evaluation to be carried out?

Evaluation was generally carried out at the end of each shift unless there was significant even or change in the patients condition.

(c) During the period when you were on duty what arrangements were in place for updating the care plan and state,

(i) How was this task performed?

Nurse caring for Raychel updated and evaluated the care plan.

(ii) Who was responsible for updating the care plan?
See above.

(iii) At what time, or in relation to what events, was updating the care plan to be carried out?
See above.

(d) The care plan records *"observe/record urinary output"* (Ref: 020-027-063). How were nurses expected to comply with this aspect of the care plan and state:

(i) In what document should urinary output have been recorded?
Fluid record sheet/ Intake and output sheet.

(ii) What was the purpose of recording urinary output?
To ensure that it was known that patients had passed urine post-operatively and were not suffering from post-op retention of urine.

(iii) For how long should urinary output have been recorded?
It was practice to record when a child passed urine until patient discharged.

(iv) Was this aspect of the care plan fully complied with?
No.

(v) If not, in what respect was it not complied with and why was it not complied with?
Raychel did use the ward toilet on at least 2 occasions which were not recorded.

(e) The care plan records, *"encourage oral fluids, record"* (Ref: 020-027-059). How were nurses expected to comply with this aspect of the care plan and state:

(i) In what document should intake of oral fluids have been recorded?

Intake and output sheet.

(ii) What was the purpose of recording intake of oral fluids?
To demonstrate the patient was tolerating oral fluids.

(iii) For how long should intake of oral fluids have been recorded?
Practice was to record until discharge.

(iv) Was this aspect of the care plan fully complied with?
No.

(v) If not, in what was respect was it not complied with and why was it not complied with?
I understand Raychel did take sips of oral fluids but these were not documented on her chart.

(f) The care plan records *"take/record vital signs ¼ hourly x 2 hours"* (Ref: 020-027-063), followed by half hourly for 2 hours etc.

Please address the following:

(i) Was this aspect of the care plan complied with?

Yes, to the best of my knowledge.

(ii) If so, where is the record of the taking of vital signs?

For immediate post-op observation staff in Recovery ward are responsible. From 1.55am -4am, Raychel had vital signs recorded as per care plan in the post-op observation sheet.

(iii) If vital signs were taken/recorded on a less regular basis, please explain why the care plan was departed from and why was it departed from?
N/A.

(iv) If applicable, was any record made of the decision to depart from the care plan in this respect?
N/A.

(16) Explain why the following matters were not recorded in the episodic care plan:

(a) The decision to contact Dr. Devlin to arrange for administration of anti-emetic medication;
No explanation.

(b) The reasons for that decision;
No explanation.

(c) The timing of the administration; and
No explanation.

(d) Its effect.
No explanation.

(17) Explain why no further entries were made in the medical notes for the 8th June 2001 after Dr. Zafar's (untimed) entry which recorded, "Apyrexial. Continue observations" (Ref: 020-007-013)?
No explanation.

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

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

(a) Do you know what has become of that document?
Post-op observation sheet for June 8th with entries made. (See sheet). Also 4 hourly observation sheet for that day commencing 10am, 2pm, 6pm, 10pm.

Post-op observation sheet used for initial observations following surgery, once patient is stable 4 hourly observation sheet is used.

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

Personally no.

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

Did not personally make an entry.

IV. QUERIES ON THE ISSUE OF FLUID MANAGEMENT

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

(19) Explain fully any action that you took in relation to the following aspects of Raychel's fluid management: I did not take part in any of the below a-f.

(a) Checking the appropriateness of the fluid that she was receiving;

(b) Checking the appropriateness of the rate of infusion;

(c) Monitoring her oral intake;

(d) Addressing the replacement of her gastric losses;

(e) Monitoring her urine output;

(f) Monitoring her vomiting.

(20) In 2001, what did you regard as the appropriate nursing approach to a child who was still experiencing episodes of vomiting more than 12 hours after surgery, and who was in receipt of hypotonic intravenous fluids? Please set out all the steps that a nurse should have taken in those circumstances.

Request Surgical doctor to review the patient and to follow his instructions or advice.
Reassure patient and their family.
Record episodes of vomiting.
Record vital signs.
Keep patient comfortable.

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

If patient was receiving IV fluids it was my understanding that the losses were being replaced and hydration was being maintained.

(22) Provide full details of any advice, training or instruction which was provided to you at Altnagelvin Hospital in order to inform you of the appropriate approach to post-operative fluid management in childrens' cases in that Hospital and state,

(a) Who provided this advice, training or instruction to you?
Prior to 2001 there was no formal or informal training on post-op fluid management in children.

(b) When was it provided?
Post 2001 and after the death of Raychel training was provided both within and outside of the Trust.

(c) What form did it take?
Informal sessions within the Paediatric Resuscitation training days held in Altnagelvin.
Hyponatraemia Fluid requirements and dehydration were discussed and taught at the sessions.
Doctor Nesbitt provided a rolling program of seminars.
Education consortium for nurses provided sessions on Fluid management for children.

(d) What information were you given?
See above.

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

For immediate 12 hours post-operatively the Anaesthetic Team were responsible for prescribing post-op fluids and checking electrolytes. Thereafter it was the responsibility of the surgical team.

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

I understand Doctor Nesbitt had meetings with Medical staff to establish and agree responsibilities.

(24) Prior to 8th June 2001:

(a) State your knowledge and awareness of the cases of Lucy Crawford, Claire Roberts, or Adam Strain, and the issues arising from those cases.
I was not aware of these cases prior to 2001.

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

(c) I was not aware of these cases prior to 2001.

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

I was not aware of these cases prior to 2001.

(25) Since 8th June 2001:

(a) State your knowledge and awareness of the cases of Lucy Crawford, Claire Roberts or Adam Strain, and the issues arising from these cases.
I became aware of Lucy Crawford's case after Raychel died but not immediately. As far as I can recall I first hear about Lucy from one of the Paediatric consultants. After some time I became aware of a link between the case of Lucy and Raychel.
I was not aware of the cases of Adam Strain and Claire Roberts until the Public Inquiry was announced into their deaths. This is what I can recall.
Overall the knowledge I had of the above cases was minimal.

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

Paediatric Consultant in Altnagelvin plus during follow up meetings with Risk Management Department after Raychel died. I cannot recall exact time or dates.

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

There have been changes in the management of post surgical paediatric patients regarding the administration of IV Fluids, protocols and guidance have been introduced.
Review of fluid balance sheet and the introduction of new sheet.
Documentation has been tightened up and improved upon, and staff are more aware of the importance of documentation on fluid balance sheets.
Reporting of untoward incidents regarding IV fluids, the importance of this has been reiterated.
Training in the management of IV fluids in children has been included in the Paediatric Resuscitation training days.

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

No

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

a. Estimated total number of such cases, together with the dates and where they took place.
Having been retired for almost 2 years I cannot recall any major cases of children with Hyponatraemia since June 2001. (Post 2001) As far as I can recall there were a small

number of Children admitted with low sodium which required prompt treatment and review. No adverse outcomes.

b. Nature of your involvement.
See above.

c. Outcome for the children.

See above.

V. GENERAL

Please address the following:

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

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

I am of the belief that the nursing care and of Raychel in Altnagelvin prior to her sudden deterioration was of a high standard. On the day of June 8th from my time of coming on duty at 7.30am to going off at approximately 6pm I did not observe any deterioration or signs in her condition that warranted any immediate intervention. Raychel had a number of vomits, buts this was not unusual in some children. Raychel had IV fluids in situ, Raychel was sitting out on her bed during the morning and walked to the bathroom twice with her father during lunch time. There were no signs of Raychel being drowsy or having increasing drowsiness.
Mr Ferguson did not raise any concerns with me ? as regards Raychel's care and treatment.
In the mid afternoon when Raychel vomited again, the surgical doctor was contacted to see Raychel and possibly give her IV anti-emetic. In the event of the surgical doctor being delayed in Theatre Doctor Devlin was requested to give Raychel the anti-emetic. The nurses caring for Raychel in particular Staff Nurse McAuley were caring, conscientious, and competent..
I would also like to reiterate that Raychel's vomits during the day of the 8th June were not I believe to be large amounts, the vomit at 10am which I saw was not large and on speaking with Staff Nurse McAuley she also agreed that Raychel's vomit at 10am was not large despite being documented as so. I do agree that the documentation of Raychel's vomits was not satisfactory. However I am as sure as I can be that the vomits were small to medium in volume.

b)Record keeping.
Nothing further to add.

c)Communications with Raychel's family about her condition, diagnosis, and care and treatment. I can only comment on the time I was on duty. I recall speaking to Mr Ferguson at least on 2-3 occasions during the morning, reassuring him regarding Raychel's vomiting and informing him of what care was planned for Raychel i.e. introduction of oral fluids, continuation of IV fluids until oral intake established. The administration of analgesia is required. I recall speaking to Mr Ferguson over the lunchtime period when he and Raychel passed me on their way to the bathroom. Mr Ferguson was wheeling Raychel's IV fluids, I offered to bring a bed-pan but Raychel did not want this. I did not speak with Mr Ferguson again as I spent time in my office

after 2pm until approximately 4.30pm - 5pm.
Mr Zafar and Doctor Makar also spoke with Mr Ferguson in the morning, Doctor Makar only briefly.
Mr Ferguson did not raise any concerns or questions to me during my time on duty or to the other nursing staff caring for Raychel.

d)Lessons learned from Raychel's death and how that affected your practice at Altnagelvin or elsewhere.
As documented in Question 25 (c), there were a number of changes introduced in the care of post -operative paediatric surgical patients and indeed all paediatric patients receiving IV fluids in Altnagelvin.
Review of IV fluids administered to all children including post-op surgical Paediatric patients.
Discontinuation of IV Solution 18 to Paediatric Patients.
Protocols/Guidance introduced. Posters placed on wards. Better awareness of the factors that can cause Hyponatraemia in Paediatric patients both Surgical and Medical.
Training of all staff both nursing and medical in the management of IV fluids administered to Paediatric patients.
Introduction of Revised Fluid Balance Sheet and training for all staff nursing and medical on the same.
Immediate reporting of all untoward incidents pertaining to Administering of IV fluids in children.
Improved awareness and knowledge on the part of nursing staff in quicker reporting of untoward problems with patients, e.g. vomiting, pain etc.
Increased vigilance and reporting of electrolytes results.

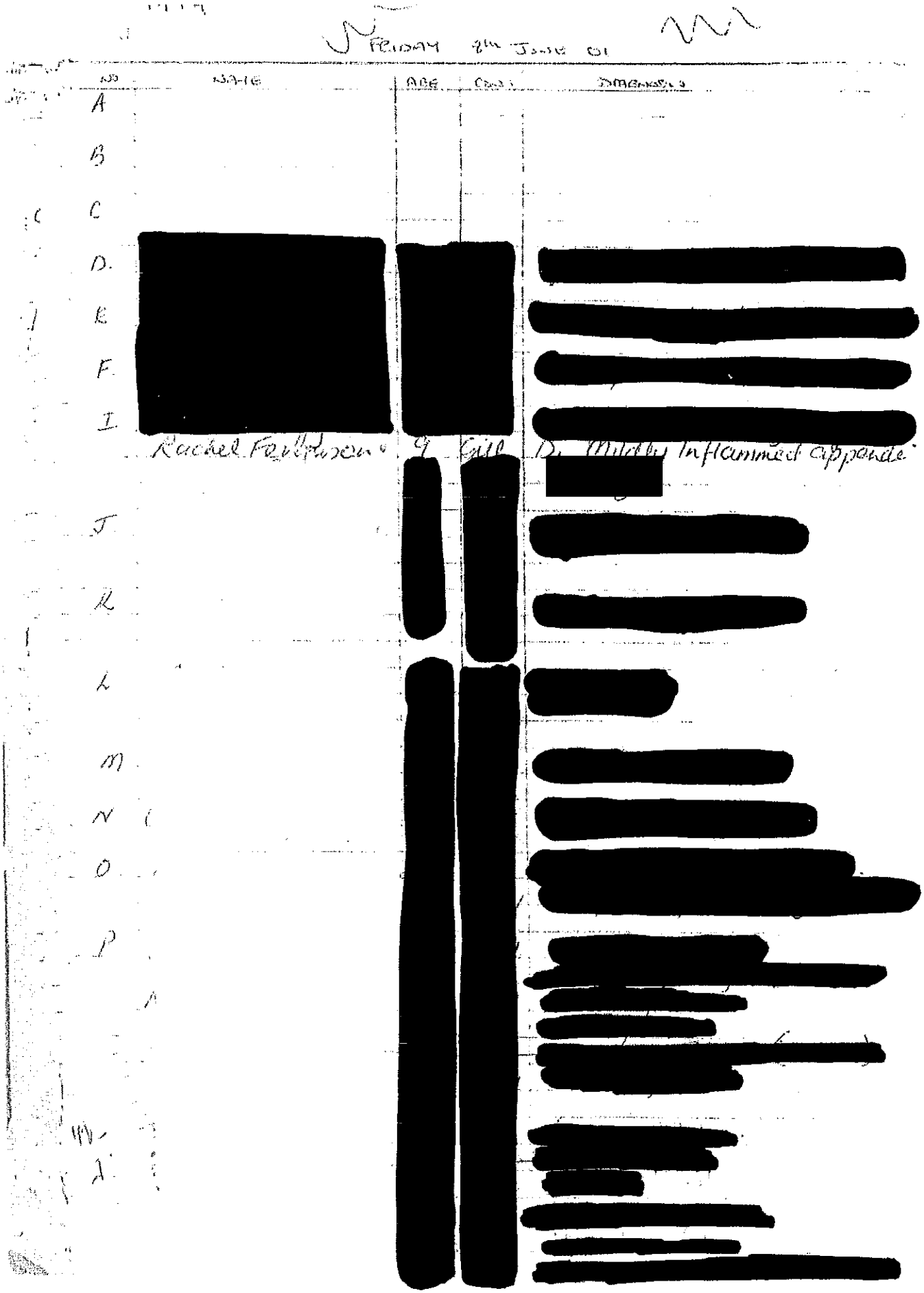
e)Current Protocols and procedures.
These would be supplied by Hospital.
Retired almost 2 years. Not aware of current protocols/procedures.

f)Any other relevant matter.

No further comments to add.

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

Signed: E.T. Millard **Dated:** 20/6/12


Friday 8th June 01
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Rachel Fairbairn
Gill
Inflammed appendix
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Allowed sips later. Esp surg DK. Analgesia. ↓ drinking ↓ ↑ fluid

[redacted]

1989.

1989

1. Job Title — Ward Sister/Charge Nurse in Paediatric Ward with continuing responsibility for the ward.

Grade: — Ward Sister/Charge Nurse G
37.5 hours per week worked as required by Nurse Management.

2. Role: — The post holder carries continuing responsibility for the assessment of care needs, the development, implementation of programmes of care and setting standards of care.

The overall management of the ward, deployment and supervision of staff, the teaching of basic and post basic learners and the development of qualified staff.

The guidance provided in the Code of Professional conduct issued by the U.K.C.C. should be taken as a standard to be achieved.

Accountable to: — Medical Nursing Officer

Reports to: — Medical Nursing Officer

3. Key Organisational Relationships

3.1 — The Ward Sister/Charge Nurse will be accountable to the Nursing Officer.

3.2 — He/She will advise the Nursing Officer of daily work load, staff requirements and absences etc.

3.3 — He/She will require to arrange instruction and experience, within the ward for learners in accordance with the requirements of the National Board.

3.4 — He/She will liaise with the College of Nursing in relation to learner assessments.

3.5 — He/She will participate in assessment of learners as required.

3.6 — He/She will co-operate with Clinical Teachers while working on the clinical area to meet the objectives of learners.

3.7 — He/She will liaise with other departments i.e. Health Visitors, Social Workers, School Teachers, Playleaders, Pharmacists, Physiotherapists, Community Nurses, Laboratory Technicians, X-Ray Staff and Chaplains.

3.8 — He/She will liaise with the Fire Officer in arranging Fire Drills for all staff.

3.9 He/She will ensure all staff are familiar with hospital policies, making every effort to safeguard the health, safety and welfare of patients, staff and visitors.

3.10 He/ She will ensure that confidentiality is maintained at all times.

4. Responsibilities

4.1 He/She must aim to provide a high standard of individualised patient care within the ward.

4.2 He/She will supervise the work of nursing staff and endeavour to maintain a high standard of individualised patient care.

4.3 He/She will be responsible for monitoring standards of care on the ward and ensuring high standards are maintained in consultation with the Senior Sister.

4.4 He/She will maintain personal contact with patients and communicate with an endeavour to provide Health Education for patients and parents as appropriate.

4.5 He/She will encourage parent involvement in caring for the children and a system of open visiting in the paediatric wards and encourage nursing staff to recognise the value of play in the development of the child.

4.6 He/She will emphasise to staff the importance of the psychological as well as the physical needs of the child.

4.7 He/She will participate in teaching and assessment of learners, ensuring that learner's objectives are available on the Unit and that they are met.

4.8 He/She will be actively involved in induction, in-service training and counselling of staff and will identify training needs in the ward.

4.9 He/She will carry out nursing procedures and treatments, demonstrating new techniques and the use of new equipment as necessary.

4.10 He/She will co-operate with medical staff in a problem solving approach to treatment, investigation and general care of patients.

4.11 He/She will complete appraisal forms for Staff Nurses, Enrolled Nurses and learners according to established procedures.

4.12 He/She will prepare reports for and receive reports from night staff and Nursing Administration.

4.13 He/She will maintain custody of controlled drugs - checking, and witnessing the administration of drugs as well as keeping accurate records.

4.14 He/She will be required to prepare duty rotas for all staff within the ward, having due regard to the fluctuations in work load.

4.15 He/She will liaise with Catering Officer and Dietitian in drawing up suitable menu for Children's meals and supervise the serving of meals and special diets.

4.16 He/She will be responsible for stock of ward supplies and equipment and requisitioning with due economy.

4.17 He/She will ensure that all ward equipment is maintained in good working order and prompt reporting to appropriate departments when faults arise.

4.18 He/She will endeavour to develop the clinical, teaching and managerial skills of Staff Nurses, Enrolled Nurses and learners to their full potential.

4.19 He/She will report and investigate accidents and complaints.

4.20 He/She will be responsible for reception of children and their parents and for care of patients' property.

4.21 He/She will assist medical staff in discharging of patients and their after care in co-operation with the Health Visitor, Community Nursing and Social Services.

4.22 He/She will endeavour to establish good relationships with all members of the ward team through good communication and co-operation.

4.23 She will take every reasonable opportunity to maintain and improve professional knowledge and competence.

4.24 He/She will be responsible top institute the first line in Disciplinary Proceedings, when necessary.

4.25 He/She will participate in research and trial of new equipment as requested.

4.26 He/She will be familiar with the Disciplinary and Grievance Policy of the Unit of Management.

4.27 He/She will attend courses and study days as required to promote professional development and will submit a written evaluation to the Nursing Officer upon return from the course.

Details of this job description may be changed in consultation with the post holder in the light of changing needs in the service.

2004

S-FM-H-062

ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST

WOMEN AND CHILDRENS CARE DIRECTORATE

PAEDIATRIC UNIT MANAGER

TITLE:	Paediatric Unit Manager
GRADE:	H Grade
RESPONSIBLE TO:	Clinical Services Manager
ACCOUNTABLE TO:	Clinical Services Manager
QUALIFICATIONS:	Registered Nurse Part 1, 12 of N.M.C. or R.S.C.N./Child Branch Part 8, 15 of N.M.C.

PRINCIPLE JOB RESPONSIBILITIES:

To carry continuing overall responsibility for the Children's Unit comprising of the:

i) Ward 43 Beds
ii) Day Case Unit
iii) Paediatric Out Patients Clinic
iv) Transitional Care Unit

To introduce evidence based holistic care to all areas of the Children's Unit.

To provide Professional and Clinical leadership to a Multiprofessional team and be an active member in taking children's services forward.

To act as advocate for children and their parents.
To liaise with other statutory and voluntary agencies on behalf of the children and their parents as appropriate.

To act in partnership with colleagues in the Neonatal Unit in planning training/rotation of staff to facilitate the discharge process of technology dependant babies/children.

Organizational and Clinical Management

1. To work in unison with the Consultant Paediatricians in the writing of Policies and Clinical Procedures.

2. To participate in the development and implementation of care pathways and protocols within the Children's Services.

3. To be aware of and ensure that all staff understand and comply with Trust Policies, Guidelines and Employment Legislation.

4. Ensure all staff promote equality and Human Rights Awareness within the Unit.

5. To participate in clinical audit of paediatric activity and outcomes, as directed by local and national initiatives and implement audit findings within the Trust's Clinical Governance Framework.

6. Identify development of services in line with government reports, regional and trust strategies, participating in the development of Unit Business Services Plans.

7. Liaise with Clinical Services Manager in relation to changes within the Children's Unit. Implement and evaluate agreed changes.

8. Co-ordinate resources available to the best advantage of children/parents and staff by the effective use of human resources, budget, accommodation, equipment, stores and supplies, providing a safe environment for the provision of care with the Unit.

9. Liaise with medical, nursing colleagues and other Departments ensuring high standards are achieved in the care of the neonate.

10. Deputise in the absence of Clinical Services Manager.

11. Assist in the investigation of all complaints in relation to care given within the Children's Unit and liaise as necessary with the Clinical Services Manager.

12. Recognise and participate in grievance/disciplinary procedures as appropriate within sphere of responsibility and liaise with CSM where necessary.

13. Participate in the recruitment process and selection of staff.

14. To monitor/manage sickness absence in accordance with the Trust Policy.

Professional Leadership

1. To maintain own NMC Registration adhering to its code and conduct.

2. To exercise leadership to achieve high moral by sound staff management. Promote good relationships and timely communication between all groups and grades of staff.

3. To work regularly within the clinical setting to ensure that personal skills are maintained and developed, providing a professional role model to all staff.

4. To maintain accurate and up to date records.

5. To continually update and improve knowledge of relevant research, changes and developments in nursing and professional knowledge and competence.

6. To attend Study Days/Courses and disseminate information/feedback appropriately.

7. To form links with key workers in the clinical/community areas, to ensure a network of informed personnel are available during times of planned or unplanned leave.

8. To participate in Individual Performance Review, on an annual basis, to assess present performance and future development needs.

9. To maintain a personal record of professional development.

10. To represent the Children's Unit as required, at various forums promoting the Unit in a professional and positive manner.

Clinical Governance and Quality

1. To ensure compliance with the reporting of critical incidents, investigating accidents/incidences, preventing reoccurrence where possible and advising the Clinical Services Manager as appropriate.

2. Be responsible for close monitoring of the critical incident reporting system. Initiate Clinical Audit in conjunction with Risk Management, advising the CSM of areas of concern.

3. To produce Annual Clinical Audit Reports.

4. To initiate and participate in clinical research.

5. To be actively involved in the formulation of clinical guidelines ensuring clinical practice is evidence based.

6. To ensure that a safe environment is maintained at all times.

7. To ensure all staff regularly attend mandatory courses.

8. To ensure all medical devices/equipment are appropriate for their use and are maintained in good working order.

9. To ensure that all staff are fully conversant with Child Protection Policies and Procedures and have a clear understanding and recognition of those at risk.

10. To liaise with the Trust's Child Protection Co-ordinator.

Education

1. Be accountable for own personal practice, maintaining a personal programme in relation to changes in Paediatric Practice and Technological Developments.

2. To participate in Individual Performance Review Programme, identifying personal education training needs.

3. To ensure all members of staff participate in the Individual Performance Review Programme on an annual basis and advise the CSM of training/educational requirements for staff.

4. To liaise with Tutors/Colleagues in relation to the ongoing education of staff and in-service training (including Students).

5. To organise orientation programmes and provide Supervision/Mentorship for all new staff to the Children's Unit.

6. To ensure all qualified staff are updated and aware of their responsibilities as Mentors to other staff.

7. To lead and motivate unit staff to adopt a progressive and positive attitude towards research/new projects.

8. To encourage research/surveys supporting the implementation of clinically effective practice changes.

This Job Description is intended to give an indication of the role and work of the Paediatric Unit Manager Grade H. It is not intended to be restrictive and will be subject to review at intervals.

The Trust operates a Policy on Smoking, Alcohol and Health.

May 2004

PERSONNEL SPECIFICATION

Each statement contained in the Personnel Specification must be justifiable by evidence obtainable from an analysis of the job. The specification should describe the person who is capable of doing the job adequately. Factors shown below are examples and may not be relevant for all posts. If so they should be marked "Not Applicable". Blank boxes are available to note additional factors. Please note, however, that the completion of the qualifications and/or experience section is compulsory.

POST:	H Grade
DEPARTMENT:	Women and Children's Directorate
LOCATION:	Paediatric Unit Manager, Altnagelvin Hospital
DATE:	May 04

FACTORS	ESSENTIAL	DESIRABLE
QUALIFICATIONS AND/OR EXPERIENCE	Registered Nurse Parts 1, 8, 12 or 15 of Nursing and Midwifery Council. 5 Years Post Registration experience. 3 years at F Grade or above in a Children's Unit.	Degree Advanced Diploma in Children's Studies.
KNOWLEDGE	Be familiar with current issues in relation to Strategic Planning in the care of Paediatrics – DHSSP Paediatric Association. Clinical Governance Risk Management Be familiar with Clinical Audit and provide evidence of participation. Knowledge of Evidence Based Practice.	Use of Information Technology

	Intensive knowledge in clinical skills.	

FACTORS	ESSENTIAL	DESIRABLE
SPECIAL APTITUDES	Excellent communication and interpersonal skills. Good management skills, ie. 1. Time Management 2. Budget Control 3. Leadership Skills 4. Implementing Change 5. Disciplinary and Grievances 6. Performance Review 7. Prepare information for developments to the service 8. Report Writing Skills 9. Staff Development Ability to assist Consultant in leadership of multi-disciplinary team.	

SPECIAL CIRCUMSTANCES	Team Player Flexible in working hours, on call if necessary	

INTERESTS		

SIGNATURE: ..... DATE: .....