Witness Statement Ref. No. 346/1

NAME OF CHILD: Raychel Ferguson

Name: Mary McKenna

Title: Mrs

Present position and institution:

Head of Acute and community Paediatrics and Neonatal Services

Previous position and institution:
[As at the time of the child's death]
Senior Staff Nurse, Grade F

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between November 1995-present]

None

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

None

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

Ref:	Date:	

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 such a number then please provide a copy of the document.

(1) Please provide the following information:

(a) Your qualifications as of 2001 (please also provide a copy of your CV);

Registered General Nurse (RGN)

Registered Sick Children's Nurse (RSCN)

(b) Describe your career history;

Student Nurse: December 1982 - February 1986

Staff Nurse - Adult Medicine: March 1986 - February 1987

Post Registered Student Nurse undertaking Children's Nursing Training: February 1987 - April 1988

Staff Nurse - Adult Medicine: May 1988 - June 1988

Staff Nurse - Children's Medical / Surgical & Neonatal: June 1988 - August 1993

Senior Staff Nurse - Infant Unit / General Children's Ward: September 1993 - November 2001

Ward Sister - General Children's Ward: December 2001 - March 2008

Head of Paediatrics: April 2008 to present

(c) Please describe your work commitments in 2001;

In 2001, I was a senior staff nurse on the ward. I worked full time and Sr Millar was my manager. As an F Grade I was often the nurse in charge of the shift. I supported and deputized for Sr Millar in managerial responsibilities.

(d) What was your role, what were the functions, accountabilities and responsibilities of your post, and were these reduced to writing by 2001? If so please provide a copy of the same;

I was appointed to the Infant Unit in 1993 as an F Grade senior staff nurse. Prior to this Altnagelvin had advertised F Grade positions as Ward Sister. When the Infant Unit and Ward 10 amalgamated in approximately 1995, I continued in the role of senior staff nurse and had an equal managerial role to that of Sr Kathryn Little, who was also an F Grade.

I reported to Sr Millar. As the F Grade, I was often in charge on the shift. I represented the hospital / department at some paediatric professional forums and brought back to the workplace actions from such groups. This included:

- working with Queen's University regarding pre-registration student placements

- working with other hospitals in Northern Ireland under the title "Paediatric Benchmarking",

comparing practises and aiming to improve care based on standards already devised in the UK.

As the senior staff nurse I often deputised for the Ward Manager during periods of leave.

I do not have a copy of my F Grade job description.

(e) Who was your line manager in 2001?

Sr Millar was my line manager.

(2) With reference to your letter to Mrs. Margaret Doherty dated 29th June 2000 (Ref:321-051-002) please state:

(a) The capacity in which you wrote this letter;

I wrote this letter as a senior staff nurse to my Clinical Services Manager (CSM); I had regular contact with my Clinical Services Manager and would have regularly updated her on paediatric matters both internal and external to our department at that time.

(b) The purpose of the letter;

The purpose of this letter was to bring to Mrs Doherty's attention some additional information I had confirmed, after extracting information on transfers over a number of years. I wanted to outline clearly the amount of time staff were absent from the ward when they had to accompany a child to Belfast.

I believe I had a discussion with Mrs Doherty, a short time prior to writing this letter, on challenges we had at that time, covering the ward. We had been experiencing difficulties in recruiting Registered Children's Nurses to the west of the province. I believed it was important to emphasise the range of ill children that we regularly cared for and to explain the vast range of specialties that were managed on this ward.

In writing this letter I wanted to update our Clinical Services Manager (CSM) on trends and changes in acute paediatric healthcare that we had become aware of, in and around that time.

(c) Who knew this letter was being written by you;

Sr Millar would have been informed by myself and would have been given her a copy of the letter also.

(d) Whether you received a response from Mrs. Doherty and if so please provide copy or further detail as to its content;

I do not have a copy to share with the Inquiry. I do believe I received a response from my CSM, acknowledging my letter.

(e) What steps were taken as a result of this letter, and by whom;

I cannot recall what steps were taken as a direct result of this letter.

(f) Whether the concerns raised were addressed and/or resolved;

The concerns raised were acknowledged by our CSM, and I belive she shared the concern with her seniors.

(g) Whether this matter was taken up the management structure and if so to whom and with what outcome;

I am not certain of how this matter was dealt with after I wrote to Mrs Doherty but there was support for our department to advertise and recruit. We were allowed to recruit additional staff over our funded establishment.

(h) How long the problems complained of with staffing levels on Ward 6 had existed prior to writing this letter;

Within Children's Wards there are seasonal variations. A ward can be quiet one day and extremely busy the next. It is difficult to plan staffing and always have it correct. The infant Unit and Paediatric Ward merged approximately in 1996. The ward became a 43 bedded unit. Previously the Infant Unit had 18 cots and the paediatric ward had 30 beds. I believe the merger of these 2 wards may have resulted in a slight reduction in staffing. I believe that after this time the decision was made to move children with orthopaedic conditions out of the orthopaedic department, to be cared for within the Children's Ward. This was advocated as best practice to ensure safeguarding arrangements and to meet Children's Charter. As a result of additional specialties being cared for on the ward it became apparent that there were staffing deficits during episodes of peak activity or when patient dependency levels were high.

(i) Whether the nursing staff had any other concerns about practices on Ward 6 which were not expressed in this letter;

I cannot recall if they had.

(j) Whether the issues raised were referred to at any other forum or committee and, if so, please specify which?

I cannot recall if they were.

(3) With reference to your letter to Mrs. Margaret Doherty dated 3rd February 2001 (Ref: 321-051-004) please state:

(a) The capacity in which you wrote this letter;

I wrote this letter as a senior staff nurse working on the Children's Ward.

(b) The purpose of the letter;

The purpose of this letter was to highlight the experience that I had as the nurse in charge on the shift on that day. I wanted to illustrate the challenges that were encountered that day. Today, one would complete a clinical incident form with a statement attached and this would be recorded on the Datix system.

(c) Who knew this letter was being written by you;

Sr Millar was aware that the letter was written by me. I cannot recall if my other colleague Sr Little was aware.

(d) Whether you received a response from Mrs. Doherty and if so please provide copy or further detail as to its content;

I cannot recall, nor do I have a copy. As stated under 2 (d) I do believe Mrs Doherty acknowledged receipt of the letter.

(e) What steps were taken as a result of this letter and by whom;

I cannot recall what steps were taken as a result of this letter.

(f) Whether the concerns raised were addressed and/or resolved;

I cannot recall when additional staff were recruited as it was a gradual process. Our senior managers were aware of our concerns and I understand that they were seeking solutions. There were Risk Management meetings every few months, and although I did not usually attend these meetings, I believe paediatric risks were discussed and progress was monitored at subsequent meetings.

(g) Whether this matter was escalated up the management structure and if so to whom and with what outcome;

I cannot be certain to whom the matter was escalated and at what stage. However as mentioned previously at 2 (g) there was agreement at senior management level to allow paediatrics to recruit additional staff over the funded establishment.

(h) Whether there were any improvements in the situation as between your letter dated 29th June 2000 and this letter;

I cannot recall after all these years what progress there had been between June 2000 and February 2001.

(i) Why Sister Millar became a co-signatory to this letter;

I would have discussed my letter with Sr Millar before sending it to our CSM. I believe she signed the letter as we were asking that our CSM escalate our concerns to the Director of Nursing and Chief Executive.

(j) What the distinction was between holistic and task orientated care, and how this affected the quality of care provided on Ward 6;

To me holistic care meant that a nurse could give total care to her patients. He / she would assess their patients and prioritize which patients needed cared for by the more experienced staff; and which patients could be cared for by a lesser experienced or qualified nurse. The staff member would then see to the child's physical needs, monitoring their vital signs, washing them, ensuring they had their food if not fasting, give them their medications, leave them clean and fresh, with play materials or distractional therapy to help them cope with their pain or illness. By taking time with your patient you could assess if they were anxious; if their pain was severe; you could assess the physical and psychological state of the patient.

Task orientated care means that a group of staff are allocated jobs e.g. a staff member starts in one area to do perhaps the observations, whilst another might give out wash bowls, and a third person might do the medicine round. Often on night duty this would be the practice due to the smaller number of staff, but on day duty when there were more staff it was preferable that the ward was divided into areas and staff worked predominantly with their group of patients only.

(k) How and why things had become *"unsafe"*;

I cannot recall exactly why I stated 'we feel things may be unsafe' but I believe I was highlighting that when there are staff shortages, it is difficult to deliver a high standard of care and deliver safe care.

(l) Whether these concerns were brought forward to Miss Duddy and Mrs. Burnside, and if so with what outcome;

I do not know if the concerns raised in this letter were brought forward to Miss Duddy and Mrs Burnside.

(k) Whether the issues raised were referred to at any other forum or committee and, if so, please specify which?

I cannot recall.

(4) With reference to your letter to Mrs. Margaret Doherty dated 1st June 2001 (Ref: 321-051-006) please state:

(a) The capacity in which you wrote this letter;

Same as 3 (a)

(b) The purpose of the letter;

The purpose of the letter was to highlight to my CSM, 2 recent experiences I had whilst I was nurse in charge at the ward. One experience related to staff not getting breaks as one nurse was escorting transfers from both the ward and the neonatal unit. The second scenario I wanted to share was my frustration at staff working in maternity who would not come to assist in paediatrics due to potential infection risk, for which I was questioning the evidence base.

(c) Who knew this letter was being written by you;

I would have made Sr Millar aware of this letter and showed her a copy of it.

(d) Whether you received a response from Mrs. Doherty and if so please provide copy or further detail as to its content;

I do not have a copy of a response from Mrs Doherty. I am not certain if I received a written response or if the letter was verbally acknowledged.

(e) What steps were taken as a result of this letter and by whom;

I do not know what steps were taken by Mrs Doherty or others as a result of this letter.

(f) Whether the concerns raised were addressed and/or resolved;

I believe the concerns were raised and shared with senior management. I am not aware of what their plan of action was.

(g) Whether this matter was taken up the management structure and if so to whom and with what outcome;

I do not know which senior persons in the Trust this concern was escalated to. However, a decision was made to recruit outside Northern Ireland for paediatrics and a few other clinical

areas where the Trust had been experiencing significant challenges in recruiting nurses. 4 nursery nurses and 6 qualified nurses from the Philippines were recruited in 2002 to the Children's Ward.

(h) Whether there were any improvements in the situation as between your letter dated 3rd February 2001 and this letter;

I cannot recall.

(i) Why Sister Millar was not a co-signatory to this letter;

I cannot be certain why Sr Millar did not sign this letter.

(j) The reasons why help was required on an immediate basis;

I used the term immediate basis to illustrate that I required a nurse to come to Children's Ward when I had phoned the co-ordinating sister (bleep holder). Activity on a Children's Ward can change dramatically over a short period of time. A very ill child can be admitted requiring resuscitation and stabilizing and often this may require a minimum of 2 nurses to work with the medical staff in caring for a child.

(l) Whether the issues raised were referred to at any other forum or committee and, if so, please specify which?

I do not recall.

(5) **In respect of the 'Audit of Dependency Levels and Review of Staffing Establishment within the Children's Ward (Omitting Day Care Unit and Clinics)' (Ref: 321-051-007) please state:**

(a) Who initiated this Audit and for what reasons;

I initiated this audit as we wanted to produce evidence to show those not working within the paediatric clinical area, the variances that occurred on the ward. Whilst we has made our managers aware of challenges we faced in the Children's Ward, we had no dependency tool or evidence to back up our concerns.

(b) The date this Audit was undertaken and completed;

The audit occurred between December 2000 and February 2001. The findings of the audit were summarised shortly after this time.

(c) Who was responsible for this Audit and who undertook it;

I was responsible for developing the data collection tool. I had phoned other paediatric units in Northern Ireland to establish if any of them had a dependency tool that was reliable. As no unit had a reliable tool, I devised a tool which measured those tasks that were carried out by a registered nurse. Our paediatric unit was different from other District General Hospitals (D.G.H.) as we cared for a larger number of specialties. I shared the proposed tool with my senior colleagues on the ward at that time.

We started to complete this information at the end of the day shift and the night shift. The Infant Area and the main ward collected their information on separate sheets. It took a bit of time to get staff compliance in completing the sheets at the end of every shift, so we had a lead in period

of a month or two before we officially began to summarise the information collated.

Part of this audit included a 'time in motion' study, where we noted the amount of time it took for a registered nurse to leave the ward and take a patient to theatre or collect a patient from theatre. We also recorded the time off the ward, when staff accompanied children for tests outside of the ward environment.

(d) Who was provided with the findings of this Audit;

The findings of this audit were shared with Sr Millar initially. We then asked colleagues in our Information Department for assistance in demonstrating our findings in a graph. The full report was then shared with Mrs Doherty, my CSM.

(e) Who was aware of the findings of this Audit;

Mrs Doherty was made aware of the findings of this report initially by Sr Millar or myself. I cannot recall which of us gave her the report.

(f) Whether Miss Duddy, Mrs. Doherty and/or Mrs. Burnside were made aware of this Audit and its findings;

I understood that Mrs Doherty shared the report with Miss Duddy. I am not aware if Mrs Burnside was made aware of this audit / findings.

(g) Whether this Audit and its findings were presented at any hospital committee or Board and, if so, please specify which;

I recall being told that this report had been shared with the Senior Management Team of Altnagelvin.

(h) Whether any steps were taken as a result of this Audit and if so by whom;

As mentioned under 2 (g) and 3 (g), a decision was taken to recruit additional staff to the Children's Ward, over and above the funded establishment.

(i) Whether any additional staffing resources were allocated to Ward 6 as a result of this Audit or the previous letters issued to Mrs. Doherty;

Recruiting additional staff for the Children's Ward was a slow gradual process. As mentioned previously, we had difficulty in recruiting children's trained nurses to the West at that time. Whilst we had general trained nurses on the ward at that time; we endeavoured to recruit children's registered nurses, as this was a very clear recommendation in many documents at that time and still remains so.

However due to the difficulty in attracting children's nurses to Altnagelvin at that time, a decision was taken to recruit qualified staff from overseas and also to introduce skill mix with the role of the nursery nurse. Education programmes were developed locally for these staff and an extended induction period was in place to support these staff in achieving competencies required to work with children.

(j) Whether any further time was made available to nursing staff on Ward 6 for staff education, development, development of standards, clinical risk assessment, supervision, research and clinical audit, and any other matters raised in the Audit?

It was not an immediate transformation, but over the following couple of years staff education, staff development, mentorship etc. improved.

(6) *"The problem in the Children's Ward seemed to be that even if Hartmann's was prescribed, it was changed to No. 18 by default"* **and** *"some clinicians evidently feel that No.18 is the fluid they wish to prescribe, and have disagreed with the regime suggested"* **(Ref: 021-057-137) please state whether you agree with this and if so:**

(a) How and when did this *"problem in the Children's Ward"* become established;

I do not know when this practice had become established.

(b) Who was responsible for implementing and monitoring this practice;

I do not know that any one person was or could have been responsible for implementing this practice.

(c) Why was it tolerated to continue;

This practice continued because there never was anyone who questioned or challenged the use of Solution 18.

(d) Was it reviewed?

I do not know if this practice was reviewed.

(7) **Was there any discussion of Raychel's case in nurse meetings, nursing reviews, nursing audits or learning sessions? If so, please provide any record thereof and describe:**

(a) The learning derived there from;

I do not have any records. I recall sharing some of our learning from Altnagelvin with regional nurse colleagues who participated in the Paediatric Benchmarking Group. This would have been when we reviewed the IV fluid document and I shared our learning on documenting vomits in terms of small, medium, large rather than using the symbols ++. We also discussed the importance of measuring urinary output if a child was on IV fluids.

I also recall teaching on the Altnagelvin 'inhouse' Paediatric Resuscitation Training Days alongside the Resuscitation Officer. All paediatric nurses attended the training annually. Staff from A&E and Theatres also attended. IV fluid management would have been covered within this day. Hyponatraemia related deaths in children would have been referred to at this session.

(b) Those steps taken to utilise the learning?

Staff attending the 'inhouse' Paediatric Resuscitation Training would have carried out a few IV fluid calculations, to ensure they understood how to calculate fluid requirements based on weight. They also learned that normal saline helped to normalise the blood chemistry on a very sick child, and the importance of giving this fluid as a first line of treatment. We followed the teaching in the APLS Instructors Manual. An evaluation was always carried out at the end of these sessions to establish if staff had learned from the training.

(8) **Please provide the following information:**

(a) When did you first become aware of the death of Raychel Ferguson?

I cannot recall.

(b) Please advise whether you were in attendance at the Critical Incident Review Meeting, and if not whether you would have expected to have been?

I was not present. I would not have expected to have been present at this meeting when Sr Millar was attending as the manager of the ward.

(c) Was there any appraisal/review of staff performance in the aftermath of Raychel's death?

I do not recall if any staff had appraisals in the aftermath of Raychel's death. None of the staff involved ever had performance issues in their practice highlighted before, during or after this event. All the staff involved were shocked and saddened at Raychel's death and regret that they failed to see that Raychel was deteriorating despite having periods where she appeared to them to be stable.

(d) How lessons learned were to be communicated across the children's ward?

Lessons learned were communicated to staff at the start of each shift for many weeks after they were highlighted to Sr Millar. These messages would have been communicated to staff by myself or Sr Little in Sr Millar's absence and notices were also placed in key areas for staff to see about not using Solution 18 for surgical patients, and of the need for surgical patients to have daily electrolytes checked whilst they were on IV fluids.

(e) Was there any attempt to review ward practices and conventions to determine whether they were appropriate, and whether they might better be reduced to writing as clinical protocols?

I recall that we wanted to improve parent / child feedback to staff on intake / output. Notices were put in every room advising parents / children to tell staff if they had taken anything to drink, if they had been to the toilet - See Appendix 1.

Other practice changes occurred but these were shared with staff through verbal communication and monitoring of practice for compliance, i.e.

- Were IV fluid sheets completed correctly
- Was vomiting recorded in terms of small medium and large rather than using the + symbol
- Did children have electrolyte profiles checked 12 hours post operatively if they still required IV fluids.

At a later date, an IV fluid sheet specifically for surgical children was introduced. The IV fluid sheet for medical children was yellow and the IV fluid sheet for surgical children was pink. The recording side of the page was the same. However on the reverse of the pink sheet, there were prompts for staff to ensure they adhered to the standard for prescribing and checking of electrolytes. I cannot locate a copy of this sheet to demonstrate this.

(f) When were you informed of the outcome of the Critical Incident Review, by whom and in what terms; and what steps were expected to be taken by you to ensure that the recommendations arising from this Review were implemented?

I cannot recall exactly when I was informed but I do recall emphasising to staff after morning handover the recommendations that we then had to implement.

(g) Please confirm whether or not you received a report in writing into the case of Raychel Ferguson? If so please provide the same?

I did not receive a written report.

(h) What steps were expected to be taken by you to ensure that the recommendations arising from this Review were implemented?

As a senior nurse on the ward, I was to support Sr Millar in cascading the recommendations to all staff. I was expected to monitor if staff were compliant with these recommendations and to challenge if there were any issues. I also recall being involved with reviewing the IV fluid sheet.

(i) Was any consideration given to performing a detailed audit of all aspects of the case?

I am not aware.

(j) Whether the bleeper system was efficient?

The bleep system required you to enter 8 before the doctors bleep number followed by 1 and then your extension. If you did not know the doctors bleep number you asked switchboard to bleep the relevant doctor.

I believe the bleep system was ok, but I think that if staff did not know the name of the doctor they wanted, staff in switchboard may have had difficulty in bleeping a doctor e.g. switchboard may be asked to call surgical JHO rather than surgical JHO on call and as there would be more than 1 JHO for surgery during the day it caused confusion. As a result switchboard may be asked repeatedly to bleep doctors until the appropriate doctor responded.

(k) Whether the fluid balance documentation was adequate?

The fluid balance sheet used at that time should have been adequate if it had been completed accurately. However we now know that there are omissions on the fluid sheet.

(l) Whether the computerised presentation of blood results was appropriate and adequate?

I am not certain what this question refers to. I recall blood results being available to view on a computer terminal. I also recall that the Lab would phone the ward and report verbally if blood results were significant and needed urgent attention. Lab staff always asked for the name of the nurse they spoke to.

(9) In the aftermath of the death of Raychel Ferguson did you have reason to consider if there had been any systemic failings (and if so please include details)?

No I did not.

(10) Was there any reference to Raychel's case at any hospital committee meetings or in any other healthcare context? If so, please provide any record thereof.

Not that I am aware of.

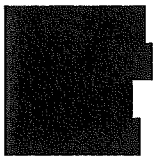
(11) **Please provide such additional comment as you think relevant. It would be of very considerable assistance if you could attach such documentation as you may hold which relates to procedures, strategies, policies or other issues you may think relevant.**

Nothing further to add.

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

Signed: Mary McKenna. **Dated:** 11/7/2013.

Curriculum Vitae for Mary McKenna



I am a motivated professional who is dedicated to promoting safer services for infants, children and young people. I possess good communication skills that enable me to represent the views of staff and patients at various professional fora. I have an extensive knowledge of paediatric nursing with over 26 years' experience in children's health care. I was highly commended in the Western Trusts Staff Recognition Awards in the Leadership Category in 2011. I was one of a team of nurses from the Western Trust who won the RCN Northern Ireland Leadership Challenge in 2011.

Areas of Expertise

Nursing:
- A professional role model
- Display leadership skills
- Holding staff to account
- Leading changes through others.
- Strive for improvement

Personal:
- Self management
- Able to deal with highly emotional situation
- Able to write reports in a compelling way
- Attention to detail

Career History

WHSCT
April 2008 - present
Head of Acute & Community Paediatrics and Neonatal Services

I am professional lead for nurses in this division of the Women & Children's directorate. I am also the service manager for this division and am the responsible budget holder for the salaries and goods & services of the teams and services within this division.

Altnagelvin Hospital
December 2001 - April 2008
G Grade Ward Manager - Children's Ward

In this post I provided nursing leadership for the services that were delivered on the Children's Unit. I was responsible for the standards of care delivered by staff in this unit.

Altnagelvin Hospital
September 1993 - December 2001
F Grade Senior Staff Nurse - Infant Unit *1993 - 1996*
- Childrens Ward *1996 - 2001*

In this post I deputized for the Ward Manager. I supervised students and junior staff members. I acted as a role model for junior staff. I developed induction programmes for student nurses.

Waveney Hospital, Northern Health & Social Services
June 1988 - August 1993
E Grade Staff Nurse

During this time I worked for lengthy periods on the Children's Medical Ward, the Children's Surgical Ward and the Neonatal Intensive Care Unit. I worked as a member of the multi-disciplinary team delivering safe patient care within these clinical environments.

Mater Hospital, Eastern Board
May 1988 - June 1988
Staff Nurse

I worked on an adult medical ward as part of the multi-disciplinary team, delivering patient care.

Queen Mary's Hospital, Carshalton, Surrey
February 1987 - April 1988
Post Reg Student Nurse

Undertaking children's nursing course.

Mater Hospital, Eastern Board
April 1986 - February 1987
Staff Nurse

I worked on a male medical ward as a junior staff nurse. As part of the multi-disciplinary team I delivered care according to doctor's instructions.

Altnagelvin School of Nursing - Western Board
December 1992 - February 1986
Student Nurse

During this time I was undertaking my general nurse training.

Academic Qualifications

Registered General Nurse (RGN) 1992 - 1996
Registered Sick Childrens Nurse (RSCN) 1987 - 1988

O Levels 1981

Maths	B
Irish	B
English Literature	B
Biology	C
English Language	C
Chemistry	C
Additional Maths	C
Religion	C

Other Academic Training

Common Core Module	1996	Western Area College of Nursing
Post Common Core Module	1997	Western Area College of Nursing
Teaching & Assessment Module	1993	University of Ulster
Supervisory Management Programme	2000	Institute for Supervision & Management
Introduction to Research Module	2003 approx	University of Ulster
Professional Issues in Nursing Module	2004	University of Ulster
Child Protection Module	2006	University of Ulster
Capital Planning & Commissioning Module	2008	University of Ulster

Other Professional Training

Ongoing Mandatory training over the years
- Infection Control
- Moving & Handling
- Health & Safety
- Child Protection

Advanced Paediatric Life Support	1997
Instructors Course to Teach on Life Support Courses	1999

Interviewing & Selection

IV Administration of Medications

Perceptorship Training

Clinical Supervision for Supervisee

Clinical Supervision for Supervisor

Clinical Nurse Leadership Programme 2002 - 2003

Selection & Interviewing updates every 2 - 3 years

I have attended various conferences, workshops and study days on paediatric services

References

Available on request

Appendix 1

ATTENTION PARENTS

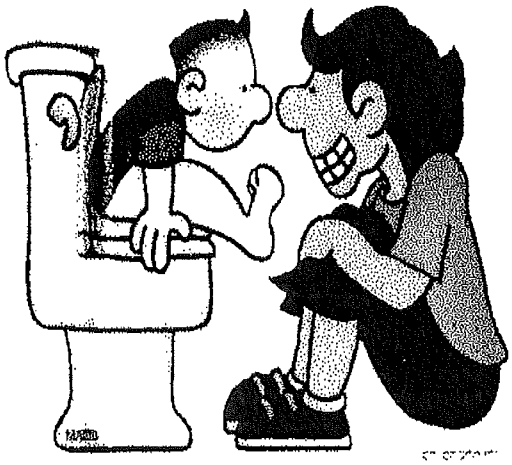
ITIS IMPORTANT THAT YOU INFORM A STAFF NURSE:

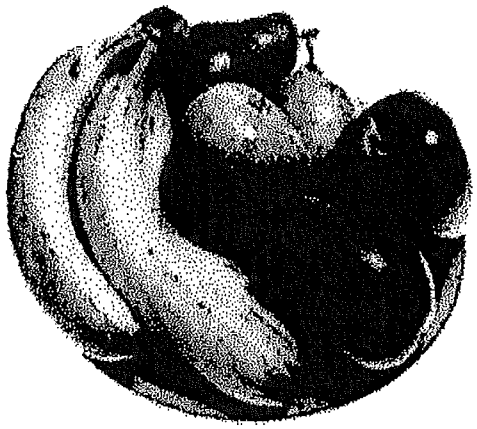
WHAT YOUR CHILD HAS HAD TO DRINK AND HOW MUCH?

WHAT YOUR CHILD HAS HAD TO EAT AND HOW MUCH?

HAS YOUR CHILD VOMITED?

HAS YOUR CHILD GONE TO THE TOILET?





YOU MUST TELL US SO WE CAN HELP YOUR CHILD.

Business Services Organisation

Directorate of Legal Services
Practitioners in Law to the Health & Social Care Sector

2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

Your Ref: Our Ref: Date:
25th June 2013

Ms A Dillon
Solicitor to the Inquiry
Inquiry into Hyponatraemia-related Deaths
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS-RAYCHEL FERGUSON

I have been passed some documentation by the Western Trust which relates to the Raychel Ferguson case. I now enclose the following for your attention:-

1. Letter dated 29th June 2000 – S/N McKenna to Mrs Doherty
2. Letter dated 3rd February 2001 – S/N McKenna to Mrs Doherty
3. Letter dated 1st June 2001 – S/N McKenna to Mrs Doherty
4. Audit of Dependency Levels and Review of Staffing Establishment within the Children's Ward.

I am instructed that Mrs Margaret Doherty, who no longer works for the Trust, requested a senior member of Trust staff to look for documentation to assist her with completion of her witness statement. The member of staff found the enclosed documentation in an old cabinet which had been in use while Mrs Doherty worked for the Trust.

The Trust apologies for the late submission of this document to the Inquiry.

Yours faithfully

JRBolton

Joanna Bolton
Solicitor Consultant

MMcK

S/N Mary McKenna
Children's Unit

29th June 2000

Mrs M Doherty
Clinical Services Manager
Women & Children's Care Directorate

Mrs Doherty,

Further to our discussion on the difficulties we are experiencing at present in providing adequate cover on the ward, I wish to make you aware about the number of patients ventilated and transferred from Altnagelvin to the Royal Children's Hospital.

In 1996 -97 we had approximately 12 patients transferred ventilated. The following year we had approximately 15. Over this last year we have been transferring on average 1 -2 per month, i.e. approximately 20 in the year (minimum). Children are being ventilated prior to transfer now, (before the situation has become one of 'resuscitation'). Those patients identified as life threatening are now often ventilated and transferred for further management, as per guidelines laid down for our medical colleagues. Such guidelines can be seen from the Advanced Paediatric Life Society.

These ventilated patients are sent from both Ward 6 and the Accident & Emergency Department where a Children's Nurse is requested as the escort. However, when this Staff Nurse leaves the ward, it often depletes the ward staff for an average of 4 hours.

It would appear an ideal opportunity if we could offer our staff a period of time in N.N.I.C.U for ventilator experience. However, in order to do so, we would need to replace these staff on the ward whilst they are out on rotation.

As you are also aware, there are times when our workload is stretched by accommodating patients from ENT and Oral Surgery when Ward 10 closes, or has a shortage of children's spaces. We also have children on the ward under the care of Dr Dickey (gastro-enterologist) and Mr Lennon (Urology).

There are often times when patients are admitted to Ward 6 who would be admitted to High Dependency Unit or Intensive Care Unit if they were in the Children's Hospital or another District General Hospital.

These patients include serious asthmatics, bad head injuries, and some toxic ingestions. These patients ideally need specialed , but often this is not practiced, which we have concerns about.

There has also been an increase in the number of patients with life-limiting illnesses surviving over the last 12-18 months, who require a lot of nursing care and are presently long-term on Ward 6.

MMc/C.

Now on reflection of the past few years since the amalgamation of Ward 6 and Infant Area, we can see an increase in the workload and in the volume of patients.

We now feel we need to address the problem of staffing levels on the ward and reach a solution.

Yours sincerely,

STAFF NURSE MARY MCKENNA
WARD 6

2

MMcK

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST
ALTNAGELVIN AREA HOSPITAL
PAEDIATRIC DEPARTMENT
LONDONDERRY BT47 6 SB
TELEPHONE – (028) 71 345171
FAX – (028) 71 611292

3 February 2001

Mrs M Doherty
Clinical Services Manager
Women + Children's Directorate
Altnagelvin Area Hospital
LONDONDERRY

Dear Mrs Doherty

I want to put in writing today (Saturday 3 February 2001), the situation as it is in Ward 6.

There were 8 trained staff this morning and 7 for the afternoon and evening.

At 8.00am I had 29 patients in total on the Ward, 10 of those were in the Infant Area, with 4 of those in oxygen, 1 being "specialed" and 3 needing close observation. Six of those patients were on monitors and 2 were receiving tube feeds.

On the main ward we had 19 patients with one patient very ill, needing "specialed".

After contacting Sister Donaghy this morning I received help, a Staff Nurse from Ward 5, who was very willing and helpful, yet inexperienced in caring for very ill children. Throughout the course of the day we had admissions and discharges, and staff were often inconvenienced and had to cut their meal breaks short.

I spent 1 ½ hours of my time this morning getting a 6th Staff Nurse to cover tonight and tomorrow night because of unexpected sick leave, and in view of the number of very ill children on the ward needing close observation and "specialing", and still trying to have staff available for the situation that might arise, eg a transfer, numerous admissions.

This evening I had a phone call from a recently discharged post liver transplant patient, and I spent 1 hour phoning doctors, pharmacists, finding notes etc to sort out a medication problem that the mother had. Again this reflects what happens regularly here; time out is taken to facilitate ward attenders out of hours or children with open access who need assessment and advice.

3

MMcK

This situation today is not unique. It appears to be a repetitive cycle of events on the Children's Ward over the last number of weeks and months. The morale of staff is falling as staff are mentally and physically exhausted, many from working extra hours and they are now frustrated at little apparent improvement in the staffing situation.

This Ward is usually divided into 4 areas, yet some days it is divided into 3, with one trained member of staff being the named nurse for more than 8 patients, and possibly up to 14. We feel this ridicules the ethos of holistic care, and we find that we are practicing task orientated care. We are now meeting this challenge annually, and we have brought our concerns forward before by writing, but unfortunately we have not found solutions, and yet we are faced with repeated situation time and time again.

I appreciate that you are equally as frustrated as we are, but we are now at the situation where we feel things may be unsafe, and staff find it very difficult to cope with the condition in which we are finding ourselves at present.

We would appreciate it if you would bring our concerns forward to Miss Duddy and Mrs Burnside.

Yours sincerely

Mary McKenna SEN.
E. T Miller.

4

HMcK

1st June 2001.

Dear Mrs Doherty,

I wish to make you aware of the difficulties and difficulties experienced recently when we have been in need of help on an immediate basis.

On 18th May ,I came on duty in the afternoon as I had been to a meeting in Antrim in the morning. Miss Gillen had asked the staff in the morning not to cancel our nurse that night as we has originally planned as our numbers were less than 20.However within 2 hours of my coming on duty we had 8 admissions, so I contacted SR Donaghy in NNICU to inform her that I would probably be unable to give her my 5th nurse that night. Throughout the evening we negotiated and reached a compromise, which was that my nurse would do a transfer from approx. 8pm-11.30pm from the NNICU, and that she was to return to WD 6 for the remainder of the night. Unfortunately she did not return as WD 6 subsequently had a transfer later in the night, with the result of the staff not getting their breaks and the ward being scarcely covered.

My second episode recently occurred on the 27th May. We had a minimum number of staff on day duty due to 2 staff off sick. SR Fitzsimmons was in contact with the ward as we were short of staff and I told her I would call her if I experienced problems. In the evening we had a new patient for urgent CT.scan, and at approx. 7.35pm we had a phonecall from the husband of S/n Doherty who was due on duty,to say that their child had taken suddenly ill.(She had an anaphylactic reaction).S/N Doherty obviously had to go to her daughter at Letterkenny Hospital. I phoned SR Fitzsimmons at this stage to inform her of the new dilemma, as the patient was going to CT at 7.45pm.and needed accompanied with a trained nurse. SR Fitzsimmons informed me that there was only one patient in labour ward and that she would ask the co-ordinator to help us out. An auxiliary nurse was sent to the ward ,because midwives will not come to the children's ward because of ?potential infection risk. Why is it then that Sho's,Registrars and consultants all can run between these units without the same risk? I have previously worked in another hospital and frequently would have gone between the children's ward and the special care unit to help when either unit was short of staff. I know that SR Fitzsimmons also was frustrated with the reluctance amongst midwives to move to our unit when an immediate need arises. I have left word with Mrs.F.Hughes (Infection Control Nurse) to see if can give me any supporting evidence either for midwives to move or not ,when this problem will inevitably occur again in the near future. In the meantime I want to ask that you give this matter some consideration, and perhaps we could discuss it further at Sr's meeting forum after we have got some more facts on the subject.

Yours sincerely

Mary Mc Kenna.

5

MMcK

AUDIT OF DEPENDENCY LEVELS

AND

REVIEW OF STAFFING ESTABLISHMENT

WITHIN THE CHILDREN'S WARD

(OMITTING DAY CARE UNIT AND CLINICS)

The reason we decided to look at the staffing levels within our Ward was as a result of discussions on staffing level comparisons, both within our hospital and province-wide.

We also wanted to find out if activity was actually increasing within our ward. Attendance appeared to be increasing, and we thought this may be a reflection of the increasing population within our local area.

There is no known dependency tool for assessing children's needs. The 'criterion for care' took is now in use for 10 years and was not designed for the care of children. We feel it is not a suitable tool to be used within our Department. We think there is no suitable tool available to determine paediatric dependency levels, which would determine staffing establishment and skill mix to provide the care needed within our department.

Our unit is very different from all other children's wards within Northern Ireland's District General Hospitals. We are unique in that we have 43 beds/cot spaces being accommodated on one ward. Our patients are medical, surgical, othopaedic, infant care and a small number of urology. We also accommodate E.N.T. and Oral Surgery when Ward 10 is closed, or if the child is very young.

We devised a method of data collection suitable for our area and following a trail year of collating information, it was decided that we needed an in-dept audit to be carried out over a three month period. The form that we used at ward level to gather this data daily is shown as **Appendix A**. This does not include duties carried out by Nursing Auxiliaries within our Department and only pertains to duties of qualified staff.

At the end of the three month period, we asked the Statistics Department to demonstrate on graph our findings. **See Appendix B**

Certain activities and processes are combined in order to allow presentation. The data is averaged over a 90 day study to indicate a staffing day in terms of hours.

The figures are a basic overview of the activities of the normal day to day in the Children's Ward. It does not take into account:

- Emergencies.
- Care of critically ill patients. (There were 3 patients ventilated during this period, however it has not been possible to demonstrate this in our audit.)
- Specialing a patient on a 1 - 1.
- Attending to the ward attenders who are seen between 5.00 pm - 9.00 am, at weekends or on bank holidays.
- The time lost when a member of staff is accompanying a patient to another Hospital. (Six hours on average per episode)

AUDIT OF ACTIVITY ON THE CHILDREN'S WARD

We have selected months December '00, January '01 and February 01 for our audit, and plan to show the average activity performed by trained staff on the Children's Unit.

The mean average of patients was 28 per day for the period chosen. The average number of admissions was 11 per day for the period chosen, however there were days when admission numbers were 20 and this audit may not reflect the activity on those days.

The average number of staff on duty is 9/8/7 Monday - Friday and 8/7/7 at weekends, and 5 trained staff at night, ie. 13 Staff Nurses x 10 hours 35 minutes on 5 days = 137 hours 35 minutes (Monday - Friday) or 131 hours (Saturday - Sunday) available of nursing time in a 24 hour period.

Nursing time available = mean average of 135 hours 43 minutes per day.

The following are a list of what we feel are trained staff responsibilities, however there are many more not included which should be given consideration when the need arises.

- Accompanying Doctors on ward rounds. = 6 hrs per day

- Checking of medications (2 Nurses in children's), 5 medicine rounds. + home leaves + prn medications + preparing and administering IV antibiotics. = 15 hrs per day

- Check emergency trolley, equipment bag (daily - 15 mins and weekly full check takes 2 hours) = average per day 30 mins

- Handover report in morning and evening, average length 30 mins (9 Nurses present receiving the report from S/N of previous shift in the morning and 5 Nurses getting report from S/N at night.) Infant area and main ward give separate reports, therefore always at least 2 Nurses handover. = 9 hours

- Informing staff after morning report of any new policies, practices, etc (9 staff) approx. 10 mins duration = 1 hr 30 mins

- Updating careplans; average 20 minutes per patient x twice daily (day and night) = 18 hrs 40 mins

- Education of patient and parent, 1 hour per patient = 28 hours per day

- Liaising with other Departments either by phone or computer (at least 14 patients per day) eg. Physio, Dieticians, ECG, X-Ray, Ambulance, etc., average 10 minutes each episode. = 2 hrs 20 mins

- Reassuring patients/parents. Answering queries from grandparents. Resolving potential complaints. It may take 4 Nurses to reassure one mother. Another mother may have got bad news and need a Nurse for many hours. In terminally ill patients the Nurse may

need to stay constantly with the parents. (One hour/ patient/day) = 28 hrs

- Wound dressings (average 2 per day) - 25 minutes each. = 50 mins
- Ordering of pharmacy (weekend 2 hours, daily 20 mins = 30 mins
- Admissions (average 11 per day, 60 minutes each). This is time taken to gather information and store same on computer. It is not time taken to reassure distraught parents or patients. = 11 hours
- Discharge (average 11.6 per day, 18 mins each). = 3 hrs 18 mins
- Tube feeds (average 3 patients per day x 5 feeds), approx. 20 minutes per feed. = 5 hours
- Checking up on blood results or x-rays and acting on any that need attention (average 10 patients per day, 10 minutes each). = 1 hr 40 mins
- Average 4.6 patients on IV fluids per day, needing site, rate and chamber checked every hour and their chart completed (average 3 minutes per patient, if no complications). = 5 hrs 30 mins
- Post op observations (average 1.5 patients/day, 1/4 hourly for first hour, 1/2 hourly for second hour, one hourly for next 4 hours = 18 sets of observations (approx. 8 minutes). = 2 hrs 24 mins
- Taking patient to and from Theatre (1.5 patient/day, 26 minutes average each time). = 78 mins
- Attending to patients on oxygen, giving holistic nursing care. These patients are very closely observed by nursing staff, needing monitors calibrated regularly, requiring regular observation of vital signs (average 3.7 patients on oxygen, needing about 8 hours

each of nursing care/day). = 29 hrs 36 mins

- Making out off duty, amending same and getting cover when staff are sick = average 40 mins/day

TOTAL = 170 hrs 26 mins

STAFFING ESTABLISHMENT DISCREPANCIES

Nursing Time Required Per Day (Pages 5, 6 and 7) = 170 hrs 26 mins

Nursing Time Available Per Day (Appendix B) = 135 hrs 45 mins

Variance Per Day = - 24 hrs 43 mins

x 7 days

= 173 hrs 1 min

÷37.5 hrs or 1 WTE

= 4.0 WTE qualified staff

Therefore 4.0 WTE are required over and above the present staffing levels to maintain services

There has been no allowance made within these times documented for staff to take their normal break, which is known as a good will break. There is also no time built in for staffs personal needs, eg. to go to the toilet.

As there is no dependency scoring system in children's nursing, it can be very difficult to explain on paper the different needs of each individual patient. Often we have patients on our unit, who ideally would be nursed in an Intensive Care Unit or High Dependency Unit, but as we are a District General Hospital we need to accommodate these children on our Ward to ensure that they get the expertise of the Children's Nurses and the Paediatric Medical Staff. Some examples of these patients are those in status epilepticus, serious-life threatening asthma, biochemistry imbalance, head injuries and trauma cases to mention a few.

Over the last four years, Sr Millar has had an increase in her ward management responsibility and is now responsible for:

- Ward Budget
- Education Budget
- Managing Absenteeism
- Individual Performance Reviews (I.P.R.)
- Interviewing of staff while on sick leave and occupational health referrals
- Formal interviewing
- Dealing with complaints and adverse incidents
- Development of Day Case Unit, Clinics on Ward 16, and Paediatric Ambulatory Care.

However, Sr is still included in the staff numbers as being available to deliver clinical care to the patients.

With clinical governance, we recognise the need for staff education and development. We also want to be able to develop standards and frameworks at ward level to enhance clinical risk assessment, clinical supervision, research and clinical audit.

However, there is no time in the average day for any of the following:

- Staff education
- Quality issues, eg. ward standards and audits
- Care pathways
- Clinical supervision
- Student Nurse Education/preceptorship on a formal basis
- Attend meetings, eg. Link Nurse Meetings for Wound Care Nurses, Infection Control Link Nurse and Diabetic Link Nurse
- Curriculum Planning Meetings
- Queens Partnership Meetings
- NI Paediatric Benchmarking Meetings
- Professional Development Meetings
- Case discussions on patients
- Discharge Planning Meetings for those patients with more complex needs
- Sisters Meetings
- IPR sessions between Sister and staff
- Ward Meetings
- Consultant Meetings
- Strategic Planning Meetings

From this information given, you can see the great difficulties and frustrations that the staff of the Children's Ward experience due to the shortfall in qualified nursing manpower.

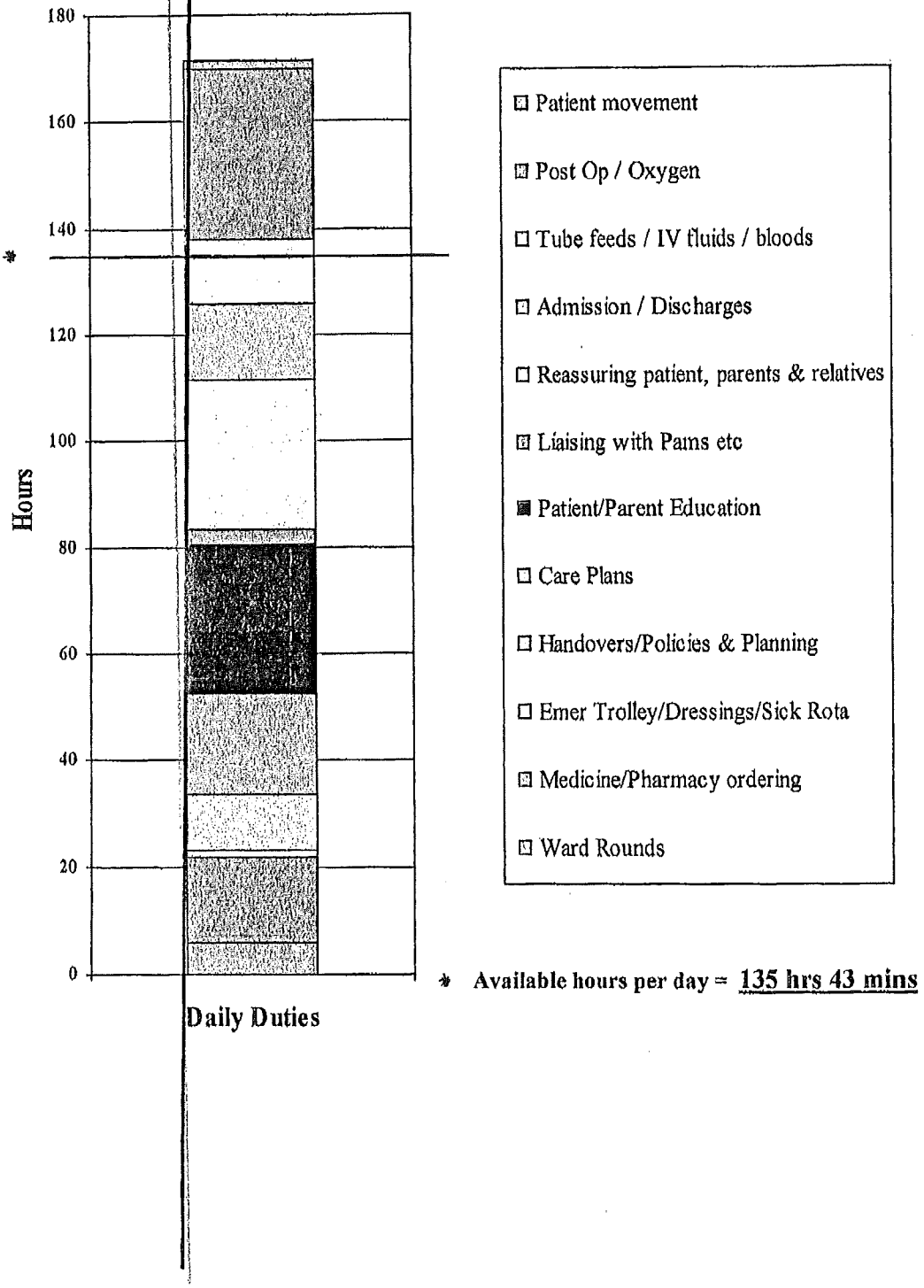
As mentioned earlier, Altnagelvins Children's Ward is unique, in the variety of patients that are cared for within it. Hence, the reason why we carried out this in-depth audit of dependency level within our ward.

APPENDIX A

PLEASE RECORD AT THE END OF EACH SHIFT

No. of Patients at 8.00am **Date**	**Area - State main ward or G-H)**	
	Day	**Night**
Number of Admissions		
Number of Discharges		
Number of Patients on IV Fluids		
Number of Patients on IV Antibiotics		
Number of Patients on Monitor		
Number of Patients Needing Hourly, Pressure Area Care (ie. Turns/Ring Care if in Traction)		
Number of Theatre Patients		
Number of Patients on Oxygen Therapy		
Number of Patients on Tube Feeds/Peg Feeds		
Number of Patients Needing Spinal Care		
Number of Patients Escorted to X-Ray or Out-Patients		
Number of Patients under 3 years of age		
Number of Wound Dressings		
Number of Patients with Tracheostomy		
Number of Patients Needing Specialed (consider bad head injury, bad asthmatics, status epileptics, etc)		
Number of Patients attending as Ward Attenders or Out-Patients. How long taken with each - state times (eg. 20 mins)		
Number of Patients Transferred to another Hospital or attending another Hospital for investigations		
Is the Ward down any Beds		

Childrens Ward
Nursing hours per day



* **Available hours per day = 135 hrs 43 mins**