The Altnagelvin Doctor's Handbook

Altnagelvin Hospitals

H&SS *Trust*

August 2004

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

Time: **RF - PSNI**

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

Place

- Fixed, known to medical/paramedical staff

Cross Cover

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

Admission ward.

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

Phone handover

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

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

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

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

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

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

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

Neil Corrigan, Postgraduate Clinical Tutor

098-090-311

[8] Patients Ca notes Standards

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

[10] Accident and Emergency Department handbook

[11] Control and Administration of Medicines

[12] Hospital Formulary

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

[14] "Do not Resuscitate" policy

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

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

[16] Laboratory services Handbook

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

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

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

BMA booklet on Consent

DoH Reference Guide to Consent for Examination and treatment

The Trust's facilities comprise:

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

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

Altnagelvin Hospital is a designated cancer unit.

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

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

Our Mission

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

In pursuit of these aims we shall:

s a priority, heed the needs of;

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

strive to develop appropriate services;

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

strive to develop constructive relationships;

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

strive to;

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

A – Z of Personnel Issues

Accommodation:

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

Annual leave:

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

Entitlement:

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

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

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

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

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

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

Frozen secti

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

RF - PSNI

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Job Interviews:

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

Locum cover:

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

Monitoring of posts:

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

Payslips:

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

Registration:

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

Phlebotomy service: **RF - PSNI**

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

Reports and Results:

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

General Guidelines:

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

Routine work: (53)

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

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

Applying for stu[illegible]eave:

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

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

Examination leave:

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

Sick Leave:

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

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

Informing the GP:

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

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

Three tier cover rota (SHO, Reg, Cons)

A&E, Anaesthetics, Obs & Gynae, Paediatrics

Ophthalmology & ENT (Shared SHO)

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

Orthopaedics, Surgery

Medicine (with two teams of SHOs)

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

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

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

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

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

...ecting your wo... ...u should make contact with the OHD (ext. ...533). All contact is confidential and details will not be shared with your colleagues or managers. Alternatively the **B.M.A** has established a counselling service for doctors (Tel. 08459 200169). Another source of help is the **National Counselling service for Sick Doctors** (0870 241 0535). This service is available 24 hours a day, 7 days a week. Calls are dealt with by doctors confidentially and, if wished, anonymously.

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

Referral after illness or injury:

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

Breaking b news to the family: RF - PSNI

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

'Do Not Resuscitate' Policy[14]:

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

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

Making wills:

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

Certifying the Death of a Patient:

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

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

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

Resources in medical education:

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

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

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

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

Administration of Blood Products:[13]

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

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

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

Administration of Chemotherapy:[9]

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

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

Consent:

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

Other Students:

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

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

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

Adverse reactions:

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

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

Hospital Formulary:[12]

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

Medication on Discharge:

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

Anti-Coagulation:

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

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

Taking part in clinical audit:

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

Some useful recommendations are as follows:

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

Procedures[13]

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

process in place designed to address the requirements of the new governance framework, which will ensure that all projects have been subjected to either internal or external peer review, have undergone scrutiny by a research ethics committee and have been costed by the finance department, so that financial implications to the Trust of undertaking the study would have been fully determined.

RF - PSNI

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Infection control:

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

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

Theatre lists:

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

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

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

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

(a) Cancellation of the list

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

(c) Any late additions or deletions

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

Patient's Advocate:

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

How to avoid complaints:

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

How to deal with complaints:

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

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

Formal detention of a patient in a general hospital:

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

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

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

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

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