HSC Business Services Organisation

Directorate of Legal Services
PRACTITIONERS IN LAW TO THE HEALTH & SOCIAL CARE SECTOR

2 Franklin Street, Belfast, BT2 8DQ
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Your Ref:	Our Ref:	Date:
BC-0044-11	HYP B04/1	9th August 2011

Ms Bernie Conlon
Secretary
Inquiry into Hyponatraemia- related deaths
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS –CLAIRE ROBERTS

I refer to the above and to your letter of 3rd August 2011 (BC-0044-11).

I enclose a copy of the RBHSC Paediatric Audit Meeting Minutes for 8th November 1996. The attendance register has not been retained. Audit Minutes are routinely deliberately constructed to avoid patient identification so there is no need to redact the Minutes. It is therefore not possible to know whether Claire Roberts' death was discussed at any particular meeting.

Yours faithfully

pp Nicola Dooley

Wendy Beggs
Assistant Chief Legal Adviser

Direct Line: [redacted]
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CONFIDENTIAL

ROYAL GROUP HOSPITALS

PAEDIATRIC DIRECTORATE CLINICAL AUDIT MEETING

Date: 8 November 1996 **Venue: Function Room**
RBHSC

Attendance: See Register

Mortality Meeting

4 cases were presented

Audit

Topic
Depth of Coding

The depth of coding was reviewed. This showed that there is room for considerable improvement, particularly in certain areas. The amount of work carried out is not being reflected accurately in the coding. The importance of accurate coding was pointed out, it will be of particular importance when the directorate progresses to cost per case.

Topic
Case Note Review

A number of charts are audited on a monthly basis

Results
Demographic information was generally well recorded, however source of Referral and Contracting Board could be improved.
Height and Weight were poorly recorded as were Development history and Immunization details.
Satisfactory details of information to parents was only recorded in 26.1% of the cases.
All entries in the case write up were signed and dated, however 35.2% were timed and 6% had the name printed.
In all cases the patient had been seen by a senior doctor.
In only 26% of the cases did each page of the notes have the patients unique ID number (this is an A standard of the Kings Fund)

In the final discharge summary in the case notes a final diagnosis was recorded in 61% of the cases and an on-going problem list in 50%
Details of information given to parents/child was only recorded in 10% of the cases.
A written medication plan was provided in 33% of the cases
In the discharge letter (hand written) only 4% contained information that had been given to parents.
The full discharge letter was completed within 14 days in 55% with a copy going to relevant people in 32%
On the operation note the signature (legible) grade of surgeon was not included in any of the 3 cases.

The case note review will continue on a monthly basis.