# The Altnagelvin Doctor's Handbook

To be miniaturized and amended by the Trust for August, 2003.

Altnagelvin HSS Trust

AUGUST, 2002

# INTRODUCTION

You are warmly welcomed as a valued member of the medical staff of Altnagelvin Hospital. I hope that you will find this booklet a useful introduction to some of the practical issues you may face while working here. Please note that this booklet is a vital part of the 'induction' programme, so I would advise you to give it your careful attention.

The scope of this booklet does not extend to the discussion of specific management protocols. You should inquire as to the protocols and guidelines available relating to your speciality at the time you commence work

Paul Neilly,
Postgraduate Clinical Tutor

# ETHICS[1]

Please remember as a guiding principle that this hospital exists ***for the relief of suffering and the treatment of the sick.***

Patients must be able to trust doctors with their lives and well being[1]. As a doctor you must:

- make the care of your patient your first concern
- treat every patient politely and considerately
- respect patients' dignity and privacy
- listen to patients and respect their views
- Give patients information in a way they can understand
- Respect the rights of patients to be fully involved in decisions about their care
- Keep your professional knowledge and skills up to date
- Recognise the limits of your professional competence
- Be honest and trustworthy
- Respect and protect confidential information
- Make sure that your personal beliefs do not prejudice your patients care
- Act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise
- Avoid abusing your position as a doctor
- Work with colleagues in the ways that best serve patients' interests

*Confidentiality* is an essential concept to grasp early in your career. It is easy to pass on confidential information unwittingly to others through conversation in public places (e.g. staff restaurant), or by leaving hospital notes or computer passwords unattended. In discussion with relatives, please be careful not to disclose information about the patient without first obtaining the patient's consent to do so. Do not store identifiable information about patients on computer without first obtaining their written consent to do so (see Data Protection Act). If at all possible, personal

information should not be stored at all on the computer and should always be password protected. *Never give confidential information about patients to third parties over the telephone.*

## REGULATIONS/RESPONSIBILITIES/RECOMMENDATIONS[2,3,4]

### 1. 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. It is of the utmost importance that you ensure that your registration and medical protection subscriptions are up to date. Acceptance of your appointment will be taken as an indication that you agree with the terms of your contract. Please also note that the GMC will take a very dim view of doctors who leave the service without due notice, as this can seriously endanger the health of the patients under their care.

### 2. Duties

- Whilst on duty, you should devote your whole time to the duties assigned to you. If you are being asked to perform non-urgent duties by staff outside your 'team' within working hours, you should inform your senior colleagues.
- You must be *punctual*. Attendance at consultant ward rounds is important, and if you are not able to attend you should excuse yourself. On-call rooms are provided on-site for PRHOs and SHOs, who should not sleep outside the hospital when on duty without the permission of the Consultants concerned.
- You are responsible for ensuring that you may be contacted at all times when on duty. You should ensure that regular checks on your **bleep battery** are carried out, and fresh batteries obtained without delay from the telephone exchange. You should keep the telephone operator informed of your whereabouts when on duty if you are not carrying a bleep, or if you leave the hospital main building.
- You are not entitled to 'half days' during the working week, unless specified on your full time shift or as part of existing arrangements for time off after a night on call.
- If you need to, you may absent yourself from the Hospital for a short time, provided your department is not busy and there is adequate cover. You must, however, arrange personally with a colleague to be responsible for your Department during such absence and *must inform the charge nurse/ward sister of the department* and the telephonist of the arrangements you have made.
- So far as your clinical work is concerned, you will be responsible directly to the Consultant(s) to whom you are assigned. If you think you have made an error in the management of a patient, it is your duty to inform the Consultant in charge of the patient without delay.

- All medical staff are asked to *dress* and behave appropriately when on duty. Wearing 'theatre greens' all day is not encouraged, and the same applies to the wearing of running shoes! There are hospital policies that severely restrict ***smoking*** to designated areas within the Trust, and appearing at work under the influence of ***alcohol*** is a major disciplinary offence. Absence from work due to a hangover is unprofessional and may lead to disciplinary action. You should also be careful not to exceed the bounds of acceptable behaviour when off-duty, especially within the hospital grounds. You should not cause or permit excessive noise in your quarters that causes disturbance to patients, nursing staff or to your colleagues.
- All medical staff should familiarise themselves with the ***'Trust guidance on the Protection of Patient and Client information'***[3]. This document deals with situations in which you are asked to divulge information about patients to relatives or others. It also mentions the need for full consent when obtaining identifiable photographs of patients.
- In any case of serious dereliction of duty that threatens the patient's safety, the Medical Director may, on the advice of a Consultant or Clinical director, and with the approval of the Chief Executive, suspend a Medical Officer. Arrest for a criminal offence may also result in suspension from duty.[2,4]
- All doctors are **required** by the GMC and Royal Colleges to attend **medical audit** meetings within the hospital.[5] A register of attendance is kept and may be sent to your supervising consultant. Apologies should be sent to the Postgraduate Secretary (3780) where attendance is not possible. As a Junior Doctor you are in a training post and should actively participate in hospital postgraduate meetings. Attendance records are kept for all scheduled meetings, and these will be made available to your supervising consultant and the relevant Royal College.
- Even when off duty you have a continuing responsibility for the patient under your care. You must, therefore, ensure that ***your colleagues on duty are fully briefed regarding all seriously ill patients in the Ward. You are expected to help cover*** *ill or absent colleagues when locum cover cannot be arranged.*
- If you fall ill, you must report immediately to the Consultant to whom you are attached, and to the Medical Personnel Office, ( Ext [redacted] ) You should also inform the above when you again take up duty.
- Altnagelvin Trust is not responsible for any articles lost from your possession, but such losses should be reported to the appropriate Clinical Services Manager so that they may be investigated. Please inform the Accommodation officer immediately if you identify areas in which security can be improved (e.g faulty locks).
- If you sustain an accident on duty this should be reported to the Medical Personnel Office and an accident form completed. (Needlestick injury – see below)

## RELATIONSHIPS WITH OTHER STAFF

### *Medical*

- You should report to the *Medical Personnel Office* (Trust Headquarters), and to your supervising consultant on your *first day at work*. You will normally be asked to go to the induction session.

- In general, as a junior member of medical staff you are a vital link in a clearly defined chain of responsibility. Part of the responsibility for your actions will ultimately rest on your supervising consultant (or the consultant responsible for the patient involved), and it is therefore important that you liase closely with him/her. The rota system is designed to allow access to your seniors for consultation at any time of the day, and you *will be expected to ask for help and advice when in doubt*. You should not wait for something to go wrong before you ask. *You must not undertake activities or responsibilities beyond those for which you have been trained*, and must be supervised at all times when training in a procedure with which you have limited experience. In general the PRHO should not undertake major management decisions without reference to his senior house officer or registrar. The job of *obtaining consent* for major procedures should normally be carried out by a practitioner with practical experience in carrying out the procedure – this duty *should not be delegated to PRHOs*.

- If you have a major *problem in the workplace*, you should make it in the first instance to your supervising consultant(s). If you are still dissatisfied you should inform the Clinical Director or finally the Medical Director. To quote the GMC "you must not make any patient doubt a colleague's knowledge or skills by making unnecessary or unsustainable comments about them" However, it is also an obligation laid down by the GMC to report serious concerns about a colleague's health and/or performance. In the first instance, such matters should be raised internally according to the Trust policy on this matter. The Medical Staff Committee will help to ensure that you will be fully supported in such circumstances.

- The **Junior Medical Staff Committee** (elected by yourselves) will elect a chairman and secretary who should attend the Medical Staff Committee Meetings and act as your representatives. They should also attend divisional meetings where possible. If the elected representative or Chairman is unable to attend a meeting he/she should send a deputy. The Chairman of the Junior Medical Staff Committee will act as a liaison officer between Junior Staff, Senior Medical Staff and Administrative Staff. A **BMA representative** should also be elected to represent you in disputes or discussions over employment issues etc., and will represent you on the Local Implementation Group on Junior Doctor's Hours and Conditions of Work.

- Effective Patient Handover to colleagues. It is your responsibility to inform your colleagues on the duty rota when a patient in your care is ill and requires attention. In the medical division this process is formalised using handover sheets and 'post-take' ward rounds. Using handover periods to offload your work onto your colleagues is unprofessional and will not go unnoticed. On the other hand,

flexibility in staying on for a few minutes when things are hectic is likely to be much appreciated.

### *Nursing and Paramedical Staff*

The ability to forge a good working relationship with your professional colleagues is a vital skill to acquire early in your training and will greatly improve the quality of care you provide to your patients. You will usually achieve these goals if you constantly bear in mind the key elements of respect and good communication. In every speciality, it is essential to work closely with nursing staff. Whilst the nursing staff (except the Clinical Service Managers) do not have managerial seniority over you, it is important to respect their advice and learn from their experience.

The roles of nursing staff are changing, with some nurses able to carry out procedures formerly regarded as medical duties (such as the ***administration of intravenous drugs***). These areas must be handled with particular ***sensitivity***. It is important to show appreciation when this service is offered, but not to show antipathy toward those nurses who do not seek to extend their role.

Communication with the nursing staff is essential to the efficient running of the ward, and you must make sure that any changes in management you recommend are verbally passed on to the nurses **in addition** to documenting them in the notes. Similarly, any discussions with patients or relatives should be mentioned to the nursing staff and recorded in the notes.

Developing good working relationships with the paramedical staff, including physiotherapists, Occupational therapists, porters, radiography and laboratory staff will improve the efficiency with which you look after your patients.

## Medical Students

### Teaching

You will all recall the value of bedside teaching by junior doctors, and we would certainly encourage you to play an active role in the teaching effort. However, delegation of duties must be strictly limited: students should not prescribe drugs, and you must still complete a history and examination yourself even if a student has seen the patient.

### Consent

Although most patients are only too happy to help in the teaching of students, some are not. They may not voice their feelings spontaneously, so 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 an active role in the procedure.

### Other

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.

## YOUR EDUCATION

### *Training Status*

- **PRHO training**

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

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

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

- **Postgraduate trainees**

♦ In most cases, your post will be a post recognised for postgraduate training under the auspices of the N. Ireland Postgraduate Dean, Dr J. McCluggage. This means that in addition to fulfilling service commitments, you will be required to attend and participate in hospital Post-Graduate educational activities. All junior doctors are expected to attend an ***induction course*** on the day of arrival at the hospital.

The College Specialty Tutor will have organised a structured education programme, and the Dean expects a *70% attendance* record at these meetings. Your supervisors are also expected to teach you, both 'on the job' and in dedicated seminars (such as lunch time sessions). In some cases these arrangements are formally stated in an Educational Agreement, and in most training schemes logbooks are provided for completion. Refresher sessions in Resuscitation techniques are provided and organised by the Resuscitation Officer.

A requirement to attend and *participate in audit* is laid down for *all medical practitioners* by the GMC. Attendance at all meetings is monitored, and failure to attend and participate may be commented on in future job references. You should attend the monthly hospital audit meetings as well as the audit meetings within your department. When you wish to carry out an audit, please use **the Audit Request Form**, available from the **Clinical Audit Assistant.** (ext. 3466)

**SHOs in Medicine** are asked to complete the logbooks provided by the Royal College of Physicians and maintain regular contact with their nominated educational supervisor. The Royal College core curriculum is available from the College Tutor. **Medical Specialist Registrars** are asked to ensure that they have the full Royal College documentation and find out which consultants are responsible for their supervision. They must have regular appraisal meetings with their educational supervisor. If there are any problems with the training program, they should voice their concerns as soon as possible. For those who wish to pursue a **career in General Practice**, special training sessions are provided with the help of GP tutors. They must complete both GP and RCP log books. In addition to the appraisals, an in-training assessment (RITA) will be completed at the end of each six-month period. Those who wish to sit MRCP part 2 clinical examinations should ask for appropriate teaching sessions, which will be provided on an individual or small group basis.

### *Appraisal*

The exact requirements for appraisal vary between specialities, but in general this is becoming a universal requirement for doctors in training. You will be expected to meet with your educational supervisor several times throughout your job. These meetings are to draw up a training plan and monitor your progress. Logbooks should be brought for discussion, and these meetings should also be used for career guidance. Your Specialty College Tutor can provide you with further details. Please take the opportunity of making use of this valuable process to obtain feedback and discuss possible career alternatives. Return the forms to the specialty tutor to confirm attendance. Repeated failure to attend appraisal meetings will be reported to the Dean and/or Royal College.

### *Resources*

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, data 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. Most meetings are held in the ***Clinical Education Centre***, which also has facilities for video-conferencing and a ***Reading and Resource room*** with computers and Internet access. This room in the Clinical Education Centre is for private study and is accessible from the main block at all hours. Access to a number of useful CD-ROM textbooks is provided in this room. Use of this room is a privilege: if abused it will be withdrawn.

Security precautions are necessary because of the expensive equipment provided. If you want to access the room after hours, you will need to apply for a ***security access card.*** This will give access to the room and record this in a log.

You are asked to adhere to the following guidelines for the Resource room:

- Please look after your card and do not share it with anyone. If you observe any suspicious activity outside the room in the evenings, please report it to the porters immediately.

- Please use discretion when using the Internet. We are connected through an NHS firewall at 'DIS' in Belfast that monitors the access to sites. ***Access and use of pornographic web sites or newsgroups through these computers is strictly forbidden***, and I do not need to remind you that you have professional responsibilities that have a bearing on this. We have an obligation to track and follow up any unauthorised internet use, which may result in the facility being withdrawn altogether. If you observe any member of staff using the internet inappropriately, please inform the postgraduate office without delay. You may use the internet to view 'non-medical' sites, but heavy 'recreational' use during working hours is discouraged. Playing internet games or listening to music will disturb other users and is also discouraged. Eating and drinking are not permitted in the room.

The facilities on offer include access to Microsoft Office including Word and Powerpoint. This will help you to prepare articles and talks. You will also have access to Internet Explorer as Web Browser, and through the web you can access the online BMJ, Medline, Cochrane and a host of other medical education resources.

## LEAVE ARRANGEMENTS

These rules apply to all forms of leave—annual leave, study leave, compassionate leave, special leave and days in lieu of Bank Holidays. Think and plan ahead – services for patients must be maintained, so the earlier you apply the better.

- ***All Junior Medical Staff must have a leave card.*** These can be obtained from the Medical Personnel Office. In the case of study leave, you will need a study leave form (also available from Personnel). Trainees in General Practice (central rotation) and Anaesthetics will need to apply to the relevant specialty committee for approval *after ensuring approval for the leave by their local Consultant* and Clinical Director
- ***STEP ONE: Requests for annual, statutory and study leave must first be approved by the relevant Consultant and leave card signed.***
- ***STEP TWO:*** Obtain approval from the **Clinical Services Manager** of your directorate (for Medicine and Surgery) and inform **Medical Personnel Officer** . They keep a central leave register for all Altnagelvin Medical Staff. You must not exceed the number of annual or study leave days agreed in your contract. Where there are conflicting requests for leave, your application for leave will be subject to further consideration and decisions by the nominated consultant will be regarded as final.
- In the *Medical Directorate*, only one PRHO, one SHO from team A, one SHO from team B and one Registrar may be off duty at any one time. This restriction particularly applies during peak holiday periods
- Not more than one PRHO should be absent at any one time from each of the rotas (Medical and Surgical).

- Specialist Registrars must also inform all their supervising consultants and the Clinical Services Manager of all leave. They ***must take special care to make alternative arrangements if they have commitments in theatre or outpatients.*** Please note that it is the responsibility of the medical officer taking leave to ensure that arrangements are made to either cover for or cancel their fixed commitments such as clinics or endoscopy sessions.
- Study leave for ***trainees in Anaesthetics and General Practice (central rotation only)*** will be ***approved and funded centrally by the Specialty Advisor to the Postgraduate Dean***. This is a new scheme, and advice should be sought as early as possible on the procedures involved.
- Leave to attend job interviews outside Altnagelvin HSS trust must normally be taken in the doctor's own time and with the usual permission from the supervising consultant.

### *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. [redacted]) prior to the starting time of shift.

### *Annual Leave*

- Annual leave entitlement is as follows: -

| | |
|---|---|
| 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 |

- Days in lieu of Statutory holidays worked must be taken as soon as possible following the Statutory holidays as such days cannot be aggregated.
- You are advised to apply early in order to avoid disappointment.

### *Study Leave*[6]

- PRHOs do not have an entitlement to funded study leave.
- Study leave is granted at the discretion of the Clinical Director of the department in which you will be working at the time you are to take the leave. Study leave is generally not granted for courses outside NI where an appropriate local course of an equivalent standard exists. The Postgraduate Clinical Tutor considers the advice of your educational supervisor and the guidelines issued by the Postgraduate Dean to assess whether or not your leave should be approved and/or funded. Please note that the funds provided by the NICPMDE for study leave per trainee per year are limited and it is therefore sometimes not possible to fully fund all the requests received. We do strive to ensure an equitable distribution of funds between trainees.
- You should apply for your leave at the earliest possible opportunity. ***Retrospective requests for funding will not be considered.*** When requesting study leave, you

must use the *SL1* form available from **the Medical Personnel Officer.** You should complete this form and forward it to your Head of Department for signature. It is then countersigned by the Clinical Director, handed in at **Medical Personnel Office** who will forward the form to the Secretary responsible for Study Leave and finally to the Postgraduate Tutor for final approval. If you have been given a study leave booklet by 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. Please note that ***exam fees are not payable*** from the study leave budget. Please note that an administration fee of £30 for courses arranged by the NICPMDE in Belfast cannot be claimed back from the study leave budget.

- **Study Leave** Entitlement

  Specialist Registrars

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

  SHOs

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

  PRHOs

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

- You are ***responsible for payment of all examination fees***, but funds will be available to support travel and accommodation for legitimate postgraduate exams. These funds will generally not be available to support the third and subsequent attempts, and will not be granted if the doctor applying has already obtained the equivalent degree in another centre.

- Applications for study leave outside the hospital will be expected to conform to the educational objectives identified with your educational supervisor. Approval for such leave may be withheld if you have not attended local postgraduate medical meetings.

- Most general training courses are provided locally in NI, and as a rule SHOs will not be supported for courses elsewhere in the UK. Funded leave for specialised training courses may be appropriate for specialist registrars who have obtained their basic post-graduate qualifications, and they should be entitled to one trip within the UK. Senior specialist registrars are entitled to attend two UK meetings, and support will be for attendance at recognised meetings abroad if presenting a paper.

- You are expected to use the cheapest form of transport available (within reason), and share private transport with colleagues where possible.

- In order to achieve an equitable distribution of study leave, the Postgraduate Dean has allocated a sum of money per SHO / SpR per year. If your application is likely to exceed this sum, the Postgraduate Tutor may ask you to sign a form to agree to be bound by this limit.

### *Compassionate Leave*

Details may be obtained from the Medical Personnel Office.

## ROTA AND ON-CALL ARRANGEMENTS

Prior to starting work in the hospital, it is your duty to contact the hospital before you arrive to *find out when you will first be on call.* Although every attempt is made to ask doctors staying on at the hospital to cover the first night, this will not always be possible.

On-call rotas are normally drawn up in each department by a representative from each tier of the rota, but copies of rotas are also maintained in the telephone exchange. Completed rotas must be returned to the Medical Personnel Office 5 working days before the end of each month so that the Clinical Director can approve them before circulation. *Colleagues, ward staff, Medical Personnel and the telephone operators must all be informed of any changes* made to the rota. This also applies to any exchanges between staff on wards during the daytime. All staff that intend to take leave should inform the doctor co-ordinating the rota as soon as possible so that cross cover can be arranged. If problems are anticipated with cover for whatever reason, inform the Clinical Director as soon as possible.

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

Some rotas have recently been changed to partial and full shift rotas. It is important that you are fully aware of the type of shift that you are involved with and it is also essential that you adhere to the starting and finishing times. It is also important that you take natural breaks if included as part of your rota.

### Pre-Registration House Officers

Normally **two Pre-Registration House Officers** will be on duty from 5.00 p.m. to 9.00 a.m., one 'Medical' and one 'Surgical'. Duty rooms are provided to allow these officers to sleep in the main hospital area when on call at night. It is ***essential*** that at all times senior colleagues are available for consultation and help within the hospital. The *Medical* Pre-Registration House Officer is responsible for Ward duties in the Medical Wards (Wards 1, 2 and 3), and Medical emergencies occurring in the Surgical Wards as necessary e.g. Cardiac Arrests. He/she accepts all admissions to appropriate Wards. The *Surgical* Pre-Registration House Officer will be responsible for care of patients on the surgical admission unit and other Surgical Wards including the Orthopaedic Wards. He/she must inform the officer coming on duty the next morning, of any problems, especially at weekends.

### *Medical Senior House Officers*

There are normally two Medical **Senior House Officers** (second on call). Both will make themselves available to advise and assist the Medical Pre-Registration House Officers. The SHO covering Coronary care (Team A) sleeps in the Duty Room on the

first floor and he/she will be primarily responsible for Medical calls to the Coronary Care Unit, ward 1 and ward 2, and A&E. This SHO will also be asked to go out in the cardiac ambulance. The arrest bleep must be personally handed over to another doctor on changing shift. The second medical SHO (Team B) will take calls from GPs requesting medical admissions, admit patients to the Geriatric Assessment Unit (ward 20 and 21) and provide cover for Ward 3 and A&E. Both SHOs will carry the cardiac arrest bleep. An SHO or more senior doctor is expected to see all non-elective patients and provide feedback to the PRHO on their clerk-in and assessment.

### Medical Specialist Registrars

The registrar tier provides additional cover. The on-call registrar is to be available to the SHOs at all times for advice and assistance. In addition, the registrar has special responsibility for the assessment of all patients admitted over the weekend. In the medical division, the registrar is expected to assess newly admitted patients in the evenings with the SHO/PRHO and discuss problems with the on-call consultant. Currently, the medical registrar has special responsibility for Spruce House long stay unit for the young disabled (in Gransha park), for urgent medical referrals from surgical wards, and for medical cover for Anderson House (Dermatology).

## SURGICAL SHOs:

SHOs are expected to support the PRHOs and see all surgical admissions. Their responsibilities are for all surgical patients based in Wards 6, 7, 8 and 9 and outlyers in other wards.

## SURGICAL SPECIALIST REGISTRARS:

Registrars are expected to provide cover for all surgical admissions, inpatients and urgent referrals from other wards. When the Urology Registrar is not on call the Surgical Registrar must provide cover.

**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)

## MONITORING:

There is a contractual obligation on employers to monitor junior doctors New Deal compliance and on individual junior doctors to co-operate with those monitoring arrangements. Where an individual junior or group of junior doctors on a rota or rotational placement fails without good reason to meet their contractual responsibility to supply monitoring data they will receive a written notice of their contractual obligation to co-operate and be required to participate in a further round of

monitoring. Persistent failure to comply with monitoring arrangements will represent a breach of contract and may result in disciplinary procedures. In such circumstances the Trust will determine what it regards as the correct pay band on the basis of the available information. The Trust is required to monitor two times per year normally for a two weeks period in September/October and March/April. (Hospital Medical and Dental Circular TC81/01). The junior doctors' contract states that "The Trust must collect and analyse data sufficient to assess hours compliance and/or to resolve pay of contractual disputes. Therefore, when the Trust reasonably requests you to do so, you must record data on hours worked and forward that data to the Trust".

## HOSPITAL ORGANISATION

### *Major Emergency Plan*[7]

Altnagelvin Trust has in place a detailed plan for dealing with major emergencies. All doctors should familiarise themselves with the contents of the plan, particularly as it pertains to them. Advice to SHOs in Accident and emergency is given on page 8; and to all other doctors from pages 13 through 15.

### *Order Communications (OCM)*

The hospital currently uses a computerised system for requesting radiology tests and ancillary services on inpatients. The results of laboratory or radiology investigations are often available via the computer system. Training will be provided for you soon after commencing work in the hospital. It is important to guard your password and not share it with others, as you have privileged access to confidential information about patients.

### *Admission policies*[8,9,10]

The surgical wards operate an alternating 'take-in' system, and in some cases pre-admission assessment clinics have been set up to reduce routine work at the weekend. PRHOs are not expected to clerk in routine admissions at the weekend. Most surgical admissions are obvious: in Altnagelvin hospital the current policy is for all patients with an acute GI bleed or acute abdominal pain to be admitted to a surgical ward. ***Children under the age of 13*** are admitted to the ***Paediatric*** Unit.

The **medical** allocation system is rather more complicated! Patients of all ages with definite or suspected acute myocardial infarction, or unstable arrhythmias, are admitted directly to the ***coronary care unit (CCU)***. Severely ill patients with LVF may also be admitted to CCU. Patients with other cardiac problems are generally admitted to ***ward 1***. Most patients under active review by the oncology team should be admitted to *ward 3* (unless they have had an MI or have an acute surgical/orthopaedic problem). The treating **oncologist** should be informed by phone as soon as possible[6]. If the patient is neutropenic due to chemotherapy, the relevant protocol should be followed without delay. Patients with respiratory problems are generally admitted to ward 3, and most of the remainder to *ward 2*. Diabetic patients with a problem not primarily related to glycaemic control go to ward 3, others to ward 2. All patients ***over the age of 75*** are normally admitted to the ***Geriatric unit***, although there may be exceptions such as patients with acute MI. Wards 20 and 21 alternate their nights on

'take'. When no beds are available in the Geriatric ward, patients in this age group may be admitted elsewhere under other teams. Patients of all ages with suspected CVA are admitted directly to the ***Stroke unit***. These guidelines are subject to change, so it is wise to acquaint yourself with the latest arrangements. It is important to remember that whatever the guidelines, the ***ill patient requiring admission should be provided with a bed without undue delay***. It is the hospital policy that all patients with suspected or definite overdose be admitted to a medical ward, and that admission should not be refused if a GP requests it. ***In the event of a cardiac arrest, the emergency number is 6666.***

Although the on-call consultant is responsible for all patients admitted to their unit 'after hours', these patients are assigned to an appropriate consultant to take over care after the on-call period. This assignment is usually decided on the basis of specialty interest, on-call rotas and recent care in outpatient clinics. The guidelines for allocation are fairly involved, so it is best to check with staff on the ward. *Under no circumstance should a patient be admitted under the care of a consultant who is on leave.* Admissions to the intensive care unit (ICU) can cause problems: the specialist registrar involved with the initial admission to ICU should inform the consultant the following day that a patient has been admitted under their care. Please refer to the ICU admission policy document for further details.

### *A & E cover*[10]

SHOs from all specialities can expect to be called to see patients in the A&E department at the request of medical staff in A&E. The registrar may also be called in the event of an emergency or where intensive care treatment is envisaged. It is important that the staff contacted should respond promptly and courteously and make other arrangements if unable to attend by reason of an emergency elsewhere in the hospital. When you attend the patient in the A&E department, you should record your findings clearly on the A&E sheet and indicate the appropriate management or disposal of the patient. The patient remains your responsibility until you hand over their care to another doctor or discharge the patient. If the patient is to be admitted please to not fully clerk in the patient in A&E: do the essentials and complete the admission in the ward. In many cases where admission is clearly indicated (agreed by A&E and medical SHOs), immediate transfer to the ward will help to reduce congestion in A&E and keep medical staff near the wards. An ECG and Chest X-ray where indicated can be organised prior to transfer provided this does not delay transfer significantly. ***An exception to this would be a patient with acute MI – thrombolysis should be administered without delay in A&E where indicated.*** If an SHO accepts a call from a General Practitioner and wishes to direct the patient to A&E for assessment (or if a bed cannot be identified), that SHO is responsible to inform A&E staff immediately and ask to be contacted as soon as the patient arrives.

## OCCUPATIONAL HEALTH

A confidential Occupational Health record has been established for you held under the guardianship of the Consultant in Occupational Health. This is separate from medical notes held by any treating doctor you have attended.

There is increasing recognition of the hazards of health care work. Local initiatives are in place to establish good practice in relation to health and safety systems and occupational health services for staff. You are strongly advised to take advantage of your *immunization update* call to the Occupational Health Department (OHD) so that any outstanding vaccinations and tests can be arranged. A more formal mechanism exists for establishing *exposure prone fitness*. This forms part of establishing fitness for Employment. You are likely to be required to abstain from exposure prone procedures until a certificate of fitness is forwarded from OHD to your clinical director.

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

If you consider that your health is or may be affecting your work you should make contact with the OHD You must seek the views of the Occupational Physician if you may be at risk of transmitting H.I.V to a patient.

The most significant workplace difficulty experienced by medical practitioners in their initial years after qualification is depressed mood due to the pressure of coping with the challenges of work combined with social isolation. The consultant in Occupational Health welcomes direct contact from staff (at his office [redacted]; or at home [redacted]). Alternatively the ***B.M.A*** has established a counselling service for doctors (tel. [redacted]). Another source of help is the ***National Counselling service for Sick Doctors*** ([redacted]: charged at local rates). This service is available 24 hours a day, 7 days a week. Calls are dealt with by doctors confidentially and, if wished, anonymously. There is also a local Staff Care Helpline on [redacted].

## PRACTICAL ADVICE

### *Case note recording*[8]

- All entries in case notes must be timed and dated. ***Entries must be easily legible and written in dark ink. Each entry should be signed and the name printed beneath the signature.*** Retrospective alterations to the notes should only be made in exceptional circumstances, and then must signed and dated with the original entry legible but scored out with a single line. Use only approved abbreviations, and above all avoid making derogatory comments about patients or other members of staff in the medical record. The entries and the signature ***must be legible.*** The Medical Personnel Office will keep a registry of signatures for future reference.
- History taking: Where helpful information may be gained from a third party, e.g., witness to a "blackout", carer of an elderly or unconscious patient, this must be obtained and documented.

- The admitting doctor should give his impression at the end of writing up the case in the form of a ***differential diagnosis.***
- A **"Problem List"** should be formulated.
- Regular daily notes after admission should be made, documenting the ***progress*** of the patient's illness and how the results of investigations have confirmed or altered the differential diagnosis.
- The use of ancillary services should be noted.
- A ***record should be made of the content of discussions with the patient and relatives.***
- The arrangements and the indications for follow-up should form a summary at the end, together with clear documentation as to the therapy that is to be continued on discharge from hospital.
- All typed correspondence must be checked and signed by the doctor who dictated them. Any corrections should be made on all copies of the correspondence.

### *Discharge summaries*

The hand-written summary should be sent with the patient with clear instructions to take it to the GP as soon as possible. ***This summary should be legible and accurate.*** It should be followed by a typed discharge summary as soon as possible (ideally within 4 days). Discharge summaries should contain the following details:

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

### *Deliberate Self Harm*

Psychiatric assessment is essential for everyone who has taken a definite overdose with deliberate intention of self-harm. This should be obtained prior to release from hospital if at all possible.

### *Discharge against medical advice*

In some cases patients will undertake to leave the ward against medical advice. If a patient admitted with deliberate self-harm wishes to discharge himself "contrary to medical advice" then careful consideration of patients' mental state is important. If you feel that the patient has a serious Psychiatric disorder with immediate risk of self-harm, you should consult the duty officer in Psychiatry in case 'formal detention' needs to be arranged (see below). In all other cases, if a patient is determined to leave

"contrary to medical advice", you must ***detail in the notes your explanation of the risks involved*** and if the patient left in the company of a friend or relative. If such a patient refuses to sign the "CMA" form, witnesses to this effect should be obtained. *You must contact the patient's General Practitioner* (or locum) as soon as possible to inform them of the patient's departure. If a patient leaves the ward in a confused state, it is important to inform security/portering staff 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/portering staff for assistance and report the incident.

### *Formal detention of a patient in a general hospital*

- A patient can be ***formally detained*** if they are suffering from a mental illness ***and*** failure to detain them would create a risk of serious self-harm or a risk towards others.
- Detention may be required 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***, or is actively suicidal.
- Detaining a patient will allow observation, but does not permit physical treatment without the patient's consent. Physical treatment can be carried out under common law where the doctor acts in the best interest of the patient to prevent serious ill harm or death. The reasons for treating someone who has been refusing treatment should be clearly recorded in the case notes. He/she may have to be monitored and staff may have to wait until there are effects of the overdose i.e. semi-consciousness, before staff can state that they had to intervene to save the individual's life.
- **Form 5A:** 'Medical practitioner's report on hospital in-patient not liable to be detained.' will detain a patient for assessment. This will hold someone for ***48 hours*** while the other forms required are being signed (forms 1 or 2, plus 3). A Form 5A is not sufficient to transfer a patient to another hospital, i.e. if they require transfer to Gransha Hospital. ***Forms 1 or 2 plus 3*** must be completed before transfer.
- **Form 1:** the nearest relative completes "Application by the nearest relative for admission for assessment". There are notes for guidance on who is the "nearest relative" on the reverse side of the form.
- **Form 2:** "Application by an approved social worker for admission for assessment". If the next of kin is not available or does not sign the form himself, an approved social worker can be asked to see the patient instead. In this case a **Form 2** is completed if the social worker agrees that he/she needs detention for assessment.
- **Form 3:** "Medical recommendation admission for assessment". If the patient's own GP is not available to complete form 3 (this would be the first preference), a doctor on the staff of Altnagelvin Hospital can complete this form, provided they have full GMC registration.

**Points of note:**

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

### *Notification of Infectious diseases:*

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

### *Infection control*

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

### *Consent*

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

### *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 and be carefully checked before submission.

2. Theatre lists must be made available to the Anaesthetic Staff on the day before surgery for routine pre-operative visits.

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

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

(a) Cancellation of the list

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

(c) Any late additions or deletions

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

### *Dental care*

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

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

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

### SHARPS:

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

### *Reporting and recording of Accidents / Critical Incidents*

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

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

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

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

### *Police and/or Press*

All enquiries from the police should be referred to the Trust's ***Police Liaison Officer*** (ext 3311) during normal working hours or the Senior Nurse / Hospital Services Manager outside these hours. Where the police request information on patients there is just ***one exception*** to the general rule that 'under no circumstances should information regarding a patient be given to anyone without the patient's full knowledge and consent'. This arises when a crime of sufficient gravity has occurred for ***public interest*** to prevail. Further details are provided in the Accident and Emergency handbook.

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 Co-ordinator. **Do not give statements direct to the Coroner's officer (usually a local Police Officer).**

### *Violence*

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

Some useful recommendations are as follows:

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

## Prescribing[11,12]

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

### *Accurate and safe prescribing*[11]

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

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

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

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

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

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

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

(vii) When initiating a new drug you have little experience with, ask a senior colleague before making a major change in therapy. You may also wish to ask the advice of the Pharmacy department who can research the literature on side effects and interactions of new or less commonly used drugs. Always record the reasons for initiating therapy in the medical notes and inform the nursing staff. Inform the General practitioner of these indications and of how long you intend the patient to take the medication. The patient should also be fully informed about their medication, and where the drug is particularly toxic, you should provide specific patient information and record that you have done so.

(viii) Take particular care with ***calculations*** of drug dosage (by age, height or weight). You must record clearly the patient's height and weight and the calculation you have performed to arrive at the dose. When you find yourself

giving more than three parenteral dosage units (i.e. three ampoules or vials), check first with the Pharmacy department.

(ix) Special attention should be given to the type and volumes of intravenous fluids presented. For example the default solution for paediatric patients is now half strength saline in 2% dextrose.

### *Adverse reactions*

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

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

### *Hospital Formulary*[12]

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

### *Medication on Discharge*

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

### *Anti-Coagulation*

If your patient has been commenced on anti-coagulants, you ***must*** fill out the form for the anti-coagulant clinic and contact the clinic to arrange the first appointment. The form should include the diagnosis, the target INR, and the proposed duration of anti-coagulation. Patients should be informed verbally and in writing of the nature, adverse effects and potential interactions of their therapy. A booklet is available, and this must be given to the patient prior to discharge from hospital.

### *Pharmacy: A valuable Information service*

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

The Pharmacy has a Medicines Help line ([redacted], or [redacted]) for the benefit of patients.

### *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.

### Administration of Blood Products[13]

Please note that 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, but please read and commit to memory the hospital's *blood transfusion policy*[13]. You will find this document particularly useful. 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. Be sure to complete all the particulars on the bottles and forms with this information at the bedside. 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. The same applies to routes of administration (e.g. intrathecal) for which you have not received adequate training and supervision.

### Invasive procedures

It is particularly important that you do not undertake invasive procedures on patients without adequate supervision and/or training. It is better to seek opportunities to learn the technique by observation during the daytime rather than to try it out unsupervised in an emergency.

## Death and Dying

A palliative care service is provided within the Trust. This is co-ordinated by Dr.A.Garvey (Palliative Care Consultant) and Nurse M. Bradley (Specialist Palliative Care Nurse).

### *Breaking bad news to a patient*

There is never a good time to break bad news, but skill, tact and empathy are needed to minimise its traumatic effect. The patient who clearly requests accurate information regarding their diagnosis and prognosis has a right to be told the truth, although this can be done with varying degrees of tact. Equally, patients who indicate that they do not wish to know their diagnosis or prognosis should have these wishes respected. If important news has to be broken to the patient it is often best to arrange for the consultant in charge to speak to the patient.

### *'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, funding may be available to assist you from the study leave budget.

### *Making wills*

- It is recommended that medical and nursing staff are not involved in the witnessing of wills as it may be held in the event of a will being contested that staff in these professions 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.
- Where for reasons of exceptional urgency and in circumstances where administrative staff are not available to assist, it may be necessary for a member of the nursing staff to undertake the witnessing of a will. Where this is the case the most senior nurse available should undertake the responsibility. This would eliminate the possibility where in the event of a will being subsequently contested, a junior nurse might be subjected to the ordeal of examination in a court on the matter of the deceased persons fitness to make a will.

### *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.

### *Breaking bad news to the family*

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

### *Death Certificates*

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

coroner? You are signing a legal document and are expected to identify those who should be referred to the coroner.

### *Cremation Certificates*

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

### *When should the Coroner be informed of a death?*

There is a ***statutory duty*** upon every Medical Officer immediately to inform the Coroner when there is reason to believe that the deceased person died, either directly or indirectly

(a) The cause of death is uncertain

(b) Death was sudden, violent or caused by an accident or misadventure.

(c) As a result of ***violence or misadventure*** or by unfair means;

(d) As a result of ***negligence or misconduct*** or malpractice on the part of others;

(e) From any ***cause other than natural illness or disease*** for which they had been seen and treated by a registered Medical Practitioner within *28 days* prior to their death.

(f) In such circumstances as may require investigation (including death as the result of the administration of an ***anaesthetic*** or immediately following an ***operation***).

(g) Was suffering from a ***notifiable industrial disease*** (e.g. Asbestos related disease)—even though it was not the cause of death.

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 Co-ordinator** (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 the Department of Forensic Pathology in the Royal Victoria Hospital, Belfast. In those cases where the decision is at the discretion of the Coroner, it is especially important that you keep the relatives informed. Requests for information regarding the result of a coroner's autopsy report should be directed either to the Coroner or to the Forensic Pathology Department in Belfast. The Laboratory and the Hospital Pathologist should not be contacted in this regard.

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

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

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

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

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

### *Informing the GP*

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

### *Dealing with stress*

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

## LABORATORY SERVICES[16]

### *Phlebotomy service*

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

### *Reports and Results*

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

### *General Guidelines*

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

### *Routine work:*

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

From Monday to Friday the bulk of routine specimens should normally be taken as early as possible in the day, preferably by 11.00 a.m., and certainly submitted to the Laboratory no later than 2.00 p.m. The Laboratory is unable to cope with large

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

### *On-call Services:*

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

### *Correct labelling and identification of specimens*

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

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

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

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

### *Frozen sections:*

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

## RADIOLOGY[17]

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

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

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

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

### *Out of Hours Radiology service*

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

### *Use of ORDERCOMS*

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

## Complaints procedures[18]

### *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.

## REFERENCES

### *Essential Reading*

The New Doctor (GMC) - for all PRHOs

Good Medical Practice (GMC) - for *all* Doctors

Maintaining Good Medical Practice (GMC) - for *all* Doctors

The Doctor as Teacher (GMC) – for *all* Doctors

British National Formulary - for *all* Doctors

### *Text References*

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

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

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

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

[5] Clinical Audit Strategy

[6] Study Leave Guidelines: NI Council For Postgraduate Medical And Dental Education
This document may be obtained from the Postgraduate Clinical Tutor or the Medical Personnel Office.

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

[8] Patients Case notes Standards

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

[10] Accident and Emergency Department handbook

[11] Control and Administration of Medicines

[12] Hospital Formulary

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

[14] "Do not Resuscitate" policy

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

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

[16] Laboratory services Handbook

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

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

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

ICU admission policy

BMA booklet on Consent

DoH Reference Guide to Consent for Examination and treatment

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

*Time:*

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

*Place*

- Fixed, known to medical/paramedical staff

*Cross Cover*

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

*Admission ward.*

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

*Phone handover*

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