The Junior Doctor's Handbook

Altnagelvin Trust

INTRODUCTION

You are warmly welcomed as a valued member of the medical staff of Altnagelvin Area Hospital. We hope that you will find this booklet a useful introduction to some of the issues you may not have come across in the text-book.

In the interest of brevity, and to maintain consensus across units, 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.

ETHICS

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 a vitally important concept to grasp early in your career. It is easy to pass on confidential information unwittingly to others through conversation in public places, or by leaving hospital notes or computer passwords unattended. In discussion with relatives, please be careful not to disclose matters for which you do not have the patient's consent to do so.

RULES AND REGULATIONS

1. Registration

All Medical Officers must be ***registered or provisionally registered medical practitioners and , members of a recognised organisation for medical protection.*** You should present your certificates to the Medical Administration Office as soon as possible. It is of the utmost importance that you ensure that your registration and medical protection subscriptions are up to date. Accepance of your appointment will be taken as an indication that you agree with the terms of your contract.

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 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.
- 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.
- 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.

- In any case of insubordination or dereliction of duty, the Medical Director may, on the advice of a Consultant/Clinical director, and with the approval of the Trust, suspend a Medical Officer.
- If you need to, and when the state of the department to which you are attached permits, you may absent yourself from the Hospital for a short time. 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.
- You are not entitled to 'half days' during the working week, except as part of existing arrangements for time off after a night 'on-call'.
- All doctors are **required** to attend **medical audit** meetings within the hospital, and apologies should be presented 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.
- 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 should be punctual. You will normally start duty at 9.00 a.m., and remain on duty until 5.00 p.m. Attendance at consultant ward rounds is important, and if you are not able to attend you should excuse yourself. On-site on call rooms are provided for PRHOs and SHOs, and you are asked not to sleep outside the hospital when on duty without permission of the Consultants concerned.

RELATIONSHIPS WITH OTHER STAFF

Medical

♦ 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 liaise closely with him/her. The on-call 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 you have been trained for, 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.

♦ If you have a **complaint**, you should make it direct to one of the following:-
The Head of the Department
The Clinical Director
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"

♦ The **Junior Medical Staff Committee** (elected by you) will elect a chairman and secretary who should attend the Medical Staff Committee Meetings and act as their spokesman. 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.

♦ You should report to the Medical Administration Office, and to your clinical director on taking office.

♦ You should not allow any noise in their quarters which causes disturbance to patients or the nursing staff.

♦ If you fall ill, you must report immediately to the Consultant to whom you are attached, and to the Medical Administration Office. You should also inform the above when you again take up duty.

♦ Altnagelvin Trust is not responsible for any articles lost from your posession, but such losses should be reported to the appropriate Clinical Services Manager so that they may be investigated.

♦ If you sustain an accident on duty this should be reported to the Medical Administration Office.

♦ Handovers 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.

Nursing and Paramedical

An important part of training of junior medical staff lies in developing good working relationships 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). 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.

Police and/or Press

Direct contact and communication with the Police or Press by junior medical staff should be avoided where possible, and the responsibility passed on to the relevant Consultant. ***Under no circumstances should information regarding a patient be given to anyone without the patient's full knowledge and consent. The patient is entitled to professional confidence.*** 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.

LEAVE ARRANGEMENTS

These rules apply to all forms of leave—annual, study, compassionate, special and days in lieu of Bank Holidays.

♦ All Junior Medical Staff must be in possession of a leave card. These can be obtained from the Medical Administration Office.

♦ The filled in leave card should then be presented to the individual's Head of Department or his deputy who will sign the card having himself made certain that the leave does not conflict with other leave within the Department.

♦ The Medical Administration Office will keep a central leave register for all Altnagelvin Medical Staff

♦ In the case of the Medical division, applications for leave must be made to the supervising consultant at the time leave is to be taken, and to the Clinical Services Manager (Miss I. Duddy) who must note conflicting leave on the form before it is finally approved. Conflicting leave will be subject to further consideration and decisions by the nominated consultant will be regarded as final.

♦ House Officers must make certain that there are sufficient numbers to maintain an adequate duty rota.

♦ Registrars must inform their supervising consultant(s), the Clinical Services Manager and the Western Area Board of all leave.

Annual Leave

♦ Annual leave entitlement is as follows:-

Senior Registrars	6 weeks
Registrars and Senior House Officers	5 weeks
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 .

♦ Annual leave cannot be carried forward to the next year. In exceptional circumstances, written permission to do so may be obtained from both your supervising consultant and the medical director.

Study Leave[2]

♦ Induction course: attendance at the induction course for Pre-Registration House Officers is mandatory. PRHOs are also to be freed from clinical duties to attend the weekly educational forum.

♦ Study leave is generally not granted for courses outside NI where an appropriate local course of an equivalent standard exists.

♦ All study leave should be proposed at the earliest possible opportunity—this particularly applies to study and examination leave. Retrospective requests for funding will not be considered.

♦ Study Leave Entitlement

Senior Registrars	1 day per week for study and research + 10 days annually
Registrars and SHOs	Maximum of 15 days per 6 months (not to be carried forward).

♦ Exam fees will not be paid, and funds will generally not be available to support the third and subsequent attempts to obtain a postgraduate examination, and will not be granted if the doctor applying has already obtained the equivalent degree in another center.

♦ In relation to leave outside NI, as a general rule SHOs should be provided with exam leave only. Advanced leave may be appropriate for registrars who have obtained their basic post-graduate qualifications, and they should be entitled to 1 trip within the UK. Senior registrars are entitled to attend two UK meetings, and support will be considered at the discretion of the local study leave committee for attendance at meetings further abroad.

Compassionate Leave

Details obtainable from the Medical Administration Office.

Sick Leave

All sick leave should be notified to the Medical Administration Office.

ROTA AND ON-CALL ARRANGEMENTS

Rotas are produced locally in the relevant departments, but up to date copies are maintained in the telephone exchange. Any changes to the rota must be documented locally and the telephone operator informed.

Duty 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'. It is ***essential*** that at all times senior colleagues are available for consultation and help within the hospital. The ***Medical*** Pre-Registration House Officer sleeps in the duty Room near the Day Surgery Unit. He/she is responsible for Ward duties in the Medical Wards (Wards 1, 2 and 3), and Medical emergencies occurring in the Surgical Wards as necessary eg Cardiac Arrests. He/she accepts all admissions to appropriate Wards. The ***Surgical*** Pre-Registration House Officer will sleep in the Duty Room on the eighth floor. He/she will be responsible for care of patients in take-in and other Surgical Wards including 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 cardiac SHO 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 man the cardiac ambulance and both SHOs will carry the cardiac arrest bleep. The arrest bleep must be personally handed over to another doctor on changing shift. The second medical SHO 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.

Medical Registrars

At present (1995) there is a registrar tier in addition to the SHOs. The 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. Currently, the 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).

A & E Officers

The **Senior House Officer** on duty will sleep in the Accident and Emergency Department. SHOs from other departments will be called to see patients depending on their complaint. Senior cover is provided by registrar / staff grade and consultant. A departmental handbook is available and regularly updated[3].

Paediatrics

The on-call tier currently comprises an **SHO, registrar** and/or consultant.

Surgery and Orthopaedics

The on-call tier currently comprises one **SHO** who covers general surgery and orthopaedics, **registrar(s)** in surgery and/or orthopaedics and consultants in surgery and orthopaedics.

Ophthalmology and ENT

The on-call tier currently comprises a common **SHO, with Registrar** and Consultant in each speciality

Anaesthetics

The on-call tier currently comprises an **SHO, Registrar** and Consultant.

PRHO DUTIES

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. This should be an exciting and challenging year, but occasionally there can be problems and stresses, and for this reason each of you has been assigned to a **supervisor**. This is a consultant (either medical or surgical) with whom you should meet on a regular basis throughout the year to discuss problems and career plans.

Efforts have been made to ensure that the rotas and working hours of PRHOs come within the prescribed hours limits, and that routine tasks such as venepuncture have been 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 **educational supervisor**.

The **PRHO forum** is an organised programme of weekly talks on practical and emergency issues which has been drawn up by the educational supervisor in discussion with last year's PRHOs. Each talk will be given by a consultant in the relevant speciality. We are committed to the principle of protected time for these sessions, and we ask for your commitment in attendance. A record of attendance will be kept and reasons sought for repeated absences.

HOSPITAL ORGANISATION

ORDERCOMS (OCM)

The hospital currently uses a computerised system for requesting radiology tests and ancillary services on inpatients. This will soon expand to provide the results of laboratory investigations. 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

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. Most surgical admissions are obvious: in Altnagelvin hospital the current policy is for all patients with an acute GI bleed to be admitted to the surgical ward.

The medical allocation system is rather more complicated! Patients with definite or suspected acute myocardial infarction are admitted directly to the coronary care unit. Patients with other cardiac problems are generally admitted to ward 1. Respiratory problems are generally admitted to ward 3, and most of the remainder to ward 2. All patients over the age of 72 are normally admittted to the Geriatric unit, although there may be exceptions as in patients with acute MI. Patients with suspected CVA are

admitted to the Geriatric unit if over the age of 65. These guidelines have been subject to change and re-assessment is contemplated, 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.

A & E cover

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 in 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.

Complaints procedures

Patient's Advocate

Complaints against doctors and other hospital staff are increasingly a fact of life. Sometimes there is reasonable grounds for complaint, sometimes not. Do 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. This individual 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.

PRACTICAL ADVICE

Case note recording

- All entries in case notes must be signed and dated. Where relevant the time at which the patient was seen should also be recorded. 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. Avoid any 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***. A registry of signatures will be kept by the Medical Administration Office 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 notes after admission should be made including the **progress** of the patient 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***, and the use of other forms of patient education such as leaflets should be recorded.
- The arrangements and the indications for follow-up should form a summary at the end, together with clear documentation as to therapy which is to be continued on discharge from hospital.

Discharge summaries

The handwritten 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 within a fortnight. Discharge summaries should contain the following details:

- A concise summary of the reason for admission.
- The results of important investigations which enabled the diagnosis to be made.
- Diagnoses, with sufficient detail to permit accurate coding.
- Procedures, with sufficent 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.

Discharge against medical advice

In some cases patients will undertake to leave the ward against medical advice. If an 'overdose' patient wishes to discharge himself "against medical advice" then careful consideration of patients' mental state is important and if necessary 'Formal Admission' should be arranged. It is better in any case if a patient is leaving 'against medical advice' for him to be discharged in the company of a relative and into their care. If such a patient refuses to sign the "AMA" form, witnesses to this effect should be obtained. If a patient leaves the ward in a confusional state, it is important to inform security and, if necessary, the police.

Suspected Psychiatric case

In any case where a major psychiatric disorder is suspected and the patient is unaccompanied by relatives, the advice of the duty officer at Gransha Hospital should be obtained and the relatives sent for. The police should be sent for only in cases where the patient is behaving in dangerous manner to others or to himself or is threatening suicide or to attack others. Where a patient urgently requiring psychiatric assessment attempts to leave hospital and refuses admission to Gransha, a form (Form 5) may be completed to detain the patient for up to 48 hours under the powers of articles 7(2) and 7A(2) of the Mental Health (Northern Ireland) Order 1986. Completion of this ***form does not authorise transfer of the patient to another hospital or institution***.

Attempted Suicide (Overdose)

Psychiatric and social assessments are essential for all definite overdoses. These should be obtained prior to release from hospital if at all possible. If not, an urgent Outpatient appointment at the Psychiatric Clinic should be given to the patient. If not seen by the Psychiatrist, then the Medical Registrar should assess the patient before discharge.

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. 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.

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 in time for routine pre-operative visits.
3. In addition to the copy of the list, which is submitted to the Theatre Superintendent, 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.

Accident / Incident recording

Accident and minor injuries occur frequently in the Wards, and can have medicolegal consequences. An accurate and legible record in the case notes is therefore essential. The following details must be 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.

Prescribing[4]

Prescribing medication is one of the most important duties as a junior doctor, and mistakes in this area can be disastrous for the patient. There are major medicolegal consequences, and if you do not take care in prescribing you lay yourself open to medicolegal action. The following general guidelines may help, but remember to ask a senior colleague and consult the BNF if you are in doubt.

Accurate prescribing

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
(ii) Avoid using proprietary names where possible
(iii) Check drug doses and route with great care
(iv) When re-writing a kardex, use the date when the prescription was first initiated
(v) When a patient is admitted, take care to obtain details of their previous prescription and continue drugs at the appropriate dosage where necessary.
(vi) When initiating a new drug you have little experience with, ask a senior colleague before making a major change in therapy. Record the reasons for initiating therapy in the medical notes and inform the nursing staff.

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[4]

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.

Pharmacy

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.

Procedures

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 aquaint yourself with any local guidelines.

Administration of Blood Products

Specific guidelines should be available by the time this booklet is published. When you take blood for group and cross-matching, it is vitally important that you ***check the patient's name and date of birth*** and fill out the bottles and forms with this information at the bedside. You should also check for previous adverse reactions to blood products.

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

Guidelines on the administration of chemotherapy are available on Ward 3. Do not undertake to administer chemotherapy without adequate supervision if you have not been trained.

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 than to try it out in an emergency.

Breaking bad news

There is never a good time to break bad news. 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 there is major news to be broken to the patient it is often best to arrange for the consultant in charge to speak to the patient.

Death

Certifying a patient dead

The Nursing Staff have been instructed that a patient who appears dead must not be removed from the Ward until the death has been confirmed by a Medical Officer. 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.

Death Certificates

Death certificates should be signed by a medical officer involved in the care of the deceased prior to 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.

Remember, have you thought about the need for a hospital autopsy?

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 offficer 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.

Resuscitation Policy

Resuscitation policies can vary. Please ensure that you are conversant with the policy in your department. It is important to attend the resuscitation classes provided and ensure that you keep up to date with the latest guidelines.

Telling 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 it is important to listen for a few minutes and to respect their greif.

Death and the coroner

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

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

(c) 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.

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

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

In addition to notifying the Coroner the member of the Medical Staff should inform the Consultant in charge of the patient.

Autopsies

Hospital autopsies have an important role in post-graduate education and in the delivery of quality 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 an autopsy is desired by the Consultant in charge, the Medical Officer will contact the next of kin and seek consent. If this is obtained the Medical Officer will make the arrangements for the autopsy with the Pathologist and will inform the Consultant in charge of the Ward of the time of the autopsy. 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.

Informing the GP

When a patient dies, the Medical Officer will inform the deceased's General Practitioner by telephone as soon as possible. Following this, he should complete the 'Notification of Death' Form

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.

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.

Making wills

♦ Medical and Nursing Staff are not encouraged to involve themselves 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 responsibility should be undertaken by the most senior nurse available. 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.

LABORATORY SERVICES

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.

Reports and Results

Results on urgent investigations should be entered into the notes, and in the case of emergency admissions this is the responsibility of the admitting doctor. These notes should be signed and any action taken or consultation with colleagues recorded. All reports from Departments, X-ray reports, etc., must be promptly signed on arrival on the ward. 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. The Medical Records Officer will advise on correct instructions for filing of individual reports.

General Guidelines[5]

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[5]:

The on-call service is provided at great financial cost and strictly urgent tests only should be requested during this period. You should identify the department(s) to which each specimen should be sent and inform the relevant personnel. Unreasonable requests submitted during on-call periods may have to be justified to the Pathologist and/or your consultant the following day. Please avoid requesting tests 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 where possible.

Correct labelling and identification of specimens

One of the simplest levels at which disastrous 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 group, 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. If the hospital number is incorrect or absent, reports will go missing and tests unnecessarily repeated. The Laboratory ***will not accept specimens which are inadequately or incorrectly labelled***. The following details are mandatory:-

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

Frozen sections:

Please arrange these directly with the Pathologists 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.

Hospital autopsies:

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. There is a separate protocol listed for obtaining a hospital autopsy and these are available on each of the Wards in the Hospital. But briefly Hospital autopsies must be arranged directly between the doctor involved and the Pathologist. Nurses and mortuary technicians must not be used as intermediaries. A signed consent form by the nearest next of kin must be obtained prior to autopsy and this should be submitted along with a brief clinical summary of the case to 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.

Coroner's autopsies:

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. Any further information regarding such autopsy reports 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.

RADIOLOGY

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"[6]. Apppropriate use of radiology services will reduce radiation exposure for your patients.

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?

Do come and 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.

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 througth the computer system out of hours will not alert the radiographer.

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 report, remember to check the ward monitor first.

Appendix

List of notifiable diseases

Acute Encephalitis	Marburg Disease	Smallpox
Acute Meningitis	Measles	Tuberculosis (Pulmonary and Non-Pulmonary)
Anthrax	Mumps	Typhoid Fever
Cholera	Parathyphoid Fever	Typhus
Diptheria	Plague	Viral Haemorrhagic Fever
Dysentery	Poliomyelitis (Paralytic and Non-Paralytic)	Yellow Fever
Food Poisoning (ALL sources)	Rabies	
Gastroenteritis (persons under 2 years of age only)	Rubella	
Infectious Hepatitis	Relapsing Fever	
Lassa Fever	Scarlet Fever	

A.I.D.S. and Legionnaires diseases should be notified under confidential cover to the Chief Administrative Medical Officer.

References

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

[2] **Study Leave Guidelines: NI Council For Postgraduate Medical And Dental Education**

This document may be obtained from the Postgraduate Officer or the Medical Administration Office.

[3] **A & E Handbook**

[4] **Hospital Formulary**

[5] **Laboratory services Handbook**

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

Doctor's Handbook

Patient Name/Details	Ward	Cons.	Diagnosis/Problems	Investigations/Results			Plan (e.g. DNR)

BC-0073-11 Reference Book No. 5.1

COURSE: **INDUCTION COURSE FOR PRE-REGISTRATION HOUSE OFFICERS**

VENUE: **LECTURE THEATRE 2**
CLINICAL EDUCATION CENTRE,
ALTNAGELVIN HOSPITALS HSS TRUST,
ALTNAGELVIN AREA HOSPITAL,
GLENSHANE ROAD,
LONDONDERRY, BT47 6SB.

DATE: **TUESDAY, 31st JULY, 2001 at 9.00 a.m.**

9.00 a.m. Tea/Coffee

9.30 a.m. **WELCOME** by Mrs.Stella Burnside, Chief Executive and Dr.Jim Moohan, Educational Co-ordinator

9.45 a.m. **THE HOUSE OFFICER'S LOT**
Dr. Joe Devlin

10.00 a.m. **NOTE MAKING/ORGANIZATION**
Dr. Philip V.Gardiner, Consultant Physician/ Postgraduate Clinical Tutor

10.15 a.m. **NEEDLESTICK INJURY/INFECTION CONTROL**
Mrs. Fiona Hughes, Senior Nurse, Infection Control

10.30 a.m. **EFFECTIVE USE OF LABORATORY INVESTIGATIONS** ON HOLIDAYS
Dr. D. F. C. Hughes, Consultant Histopathologist

10.45 a.m. **EFFECTIVE USE OF MEDICAL IMAGING**
Dr. C. S. Elliott, Consultant Radiologist

11.00 a.m. Tea/Coffee

11.30 a.m. **PHYSIOLOGICAL TESTING** by Miss Marie Hamilton, Senior ECG Technician

1200 Noon Payroll documentation (Salaries & Wages Dept.) M. McKeegan ROTAS

12.30 p.m. Lunch

1.30 p.m. **DEALING WITH AGGRESSIVE/VIOLENT PATIENT OR RELATIVE**
Mr. L. A. McKinney, Consultant in A & E Medicine

2.00 p.m. **DEATH CERTIFICATE/POSTMORTEM REQUEST**
Dr. Marie Madden, Consultant Histopathologist

2.30 p.m. **TOUR OF LABORATORY FACILITIES**
Dr. Mark Lynch

2.40 p.m. **HOSPITAL COMPUTER SYSTEMS** I.T. Department
Mrs. B. McCarron

3.30 p.m. Tea/Coffee

3.45 p.m. **PRACTICAL PROCEDURES/RESUSCITATION EQUIPMENT**
(Ward 3) Dr. H. Robinson BLOOD GAS Blood $350 ANALYSER

INDUCTION PROGRAMME
WEDNESDAY, 1st AUGUST, 2001.
****

8.45 a.m. DEPARTMENTAL WELCOME (Ward or department in which you will be working). Trainee meets Consultant, discuss duties and rota cover.

9.30 a.m. (sharp) **GENERAL HOSPITAL INDUCTION SESSION in Lecture Theatre 2, CLINICAL EDUCATION CENTRE**

Time	Topic	Speaker	Written Notes
9.30 a.m.	**Welcome to Altnagelvin**	Mrs.S.Burnside, Chief Executive	
9.45 a.m.	**General Hospital Issues** Welcome, note-keeping Professional conduct, Contact with other Professionals, Leave issues.	Dr.J.A.F.Beirne, Chairman, Medical Staff Committee	Casenote standards
10.00 a.m.	**Educational Issues** Educational programme Supervisors, Facilities	Dr.P.V.Gardiner Postgraduate Clinical	Junior Doctors' handbook
10.15 a.m.	**Welfare and Health Issues** Contact names and numbers, occupational health, needlestick injuries. Need for representatives for Medical Staff and B.M.A.	Dr.Clive Burges Consultant in Occupational Health	Formulary: Antibiotic Policy List of contact numbers
10.30 a.m.	**Tea Break**		
10.45 a.m.	**Post Mortems**	Dr.D.F.C.Hughes Consultant Histopathologist	
10.55 a.m.	**Training Issues:-** 1. Audit 2. Resuscitation	Dr.M.J.R.Parker Hospital Audit Co-ordinator Mrs.U.McCollum, Resuscitation Training Officer	

11.30 a.m. **DEPARTMENTAL INDUCTION**

Dr. K. W. MOLES, Clinical Director, Medical Directorate

CARDIOLOGY PROTOCOLS (Medical Directorate JMS)

COURSE: **INDUCTION COURSE FOR PRE-REGISTRATION HOUSE OFFICERS**

VENUE: **LECTURE THEATRE 2**
CLINICAL EDUCATION CENTRE,
ALTNAGELVIN HOSPITALS HSS TRUST,
ALTNAGELVIN AREA HOSPITAL,
GLENSHANE ROAD,
LONDONDERRY, BT47 6SB.

DATE: **TUESDAY, 6th AUGUST, 2002, at 9.00 a.m.**

9.00 a.m.	Tea/Coffee
9.30 a.m.	**WELCOME** by Mrs.Stella Burnside, Chief Executive and Dr.Jim Moohan, Educational Co-ordinator
9.45 a.m.	**THE HOUSE OFFICER'S LOT** Dr. Donna Mace, JHO
10.00 a.m.	**NOTE MAKING/ORGANIZATION** Dr. P.V. Gardiner, Postgraduate Clinical Tutor
10.15 a.m.	**NEEDLESTICK INJURY/INFECTION CONTROL** Mrs. Wendy Cross, Senior Nurse, Infection Control
10.30 a.m.	**DEATH CERTIFICATION** Dr. Rose Sharkey, Consultant Physician
10.45 a.m.	**EFFECTIVE USE OF MEDICAL IMAGING** Dr. C. S. Elliott, Consultant Radiologist
11.00 a.m.	Tea/Coffee
11.30 a.m.	**PHYSIOLOGICAL TESTING** by Miss Marie Hamilton, Senior ECG Technician
1200 Noon	ROTAS, etc., Mr.Michael McKeegan, Medical Personnel Payroll documentation (Personnel Staff)
12.30 p.m.	Lunch
1.30 p.m.	**DEALING WITH AGGRESSIVE/VIOLENT PATIENT OR RELATIVE** Mr. L. A. McKinney, Consultant in A & E Medicine
2.00 p.m.	**EFFECTIVE USE OF LABORATORY INVESTIGATIONS** by Dr. Mark Lynch
2.30 p.m.	**TOUR OF LABORATORY FACILITIES** Dr. Mark Lynch
2.40 p.m.	**HOSPITAL COMPUTER SYSTEMS** I.T. Department Mrs. B. McCarron
3.30 p.m.	**PRACTICAL PROCEDURES/RESUSCITATION EQUIPMENT** (Ward 3) Demonstration of Blood Gas Analyser by Dr. Mark Lynch and Mrs. Mairead Logue, Respiratory Nurse Specialist

INDUCTION PROGRAMME

WEDNESDAY, 7th AUGUST, 2002

8.45 a.m. DEPARTMENTAL WELCOME (Ward or department in which you will be working) Trainee meets Consultant, discuss duties and rota cover.

9.30 a.m. (sharp) GENERAL HOSPITAL INDUCTION SESSION in Lecture Theatre 2, Clinical Education Centre.

Time	Topic	Speaker	Written notes
9.30 a.m.	**Welcome to Altnagelvin**	**Mrs.S.Burnside,** Chief Executive	
9.45 a.m.	**General Hospital Issues** Welcome, note-keeping, Contact with other Professionals, Leave issues Professional conduct JMS representatives for Medical Staff And B.M.A.	**Mr. A. R. Wray** Chairman, Medical Staff Committee	Casenote standards
10.00 a.m.	**Educational Issues** Educational programme, Supervisors, Facilities	**Dr.N.P.Corrigan**	Junior Doctors' Handbook Formulary: Antibiotic policy
10.15 a.m.	**Welfare and Health Issues** Contact names and numbers Occupational health, Needlestick injuries	**Dr.C.Burges,** Consultant in Occupational Health	List of contact numbers

10.30 a.m. Tea break

10.45 a.m.	**Post Mortems**	**Dr. H.M.Vazir** Consultant Histopathologist
10.55 a.m.	**Audit**	**Dr.M.J.R.Parker,** Hospital Audit Co-ordinator
	Resuscitation	**Mrs.Ursula McCollum** Resuscitation Training Officer

11.30 a.m. Departmental Induction – Medical Directorate JMS

Dr.K.W.Moles, Clinical Director, Medical Directorate

Cardiology Protocols Dr. J. A. Purvis

BC-0073-11

Point No 6.1

Paediatric Antiemetic Guidelines
For use in post operative patients aged 12 months to 12 years.

1 Avoidance
Implement where possible, the current pre-op fasting guidelines. Provide analgesia using non opioid analgesics (eg Paracetamol 20mg/kg PO/PR, Diclofenac 1-2 mg/kg PO/PR) or a regional technique as appropriate.

Avoid intubation when a LMA is sufficient. If intubating, consider a spontaneously breathing technique rather than full ventilation.

In all other cases consider an antiemetic especially if the anaesthetic involves and opioid. Depending on the circumstances, the agent chosen could be cyclizine 1mg/kg or ondansetron 0.15 mg/kg.

For high risk patients (eg tonsillectomy) consider combining the antiemetic with dexamethasone 0.4mg/kg up to a maximum of 8mg IV.

2 Rescue antiemesis.
Any child vomiting within ninety minutes post operatively should receive (First line) cyclizine 1mg/kg IV STAT, or (Second line) ondansetron 0.15 – 0.2 mg/kg IV STAT, or whichever of the two has not already been given previously. Review the child thirty minutes later.

3. Action for severe postoperative vomiting
If vomiting persists despite two antiemetics at two hours, or if vomiting has been severe prior to this take the following action;

1. Take blood for urea and electrolytes. Mark the sample urgent, inform the laboratory and make sure to see a result in less than one hour.
2. Estimate fluid losses and replace these with the same volume of Hartmann's solution over one hour.
3. Administer ondansetron 0.15 mg/kg IV. If vomiting has been severe then add dexamethasone 0.4mg/kg IV up to 8 mg which can be used in combination and repeated eight hours later.
4. Erect an intravenous infusion of maintenance fluids at an appropriate rate. This should be Hartmann's solution if the serum sodium is 135mmol/l or less. Otherwise the default solution should be deployed.
5. Fluids should be reviewed six hours after commencement and stopped if the child is tolerating oral fluids. Otherwise a repeat urea and electrolytes should be sent, any further losses replaced and fluids prescribed for a further six hours.
6. If the child is vomiting twelve hours post operatively, or if symptoms are not settling then the patient should be reviewed by a senior doctor.

Patrick Stewart 7th April, 2003.

BC-0073-11

Point No 6.2

RF - INQ

FACILITATORS

Melanie Elliott, Nurse Education Consultant, NEDC

Dr Patrick Stewart, Consultant Anaesthetist, Altnagelvin Hospital

Dr Cathy Campbell, Paediatric SHO, Altnagelvin Hospital

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Clinical Education Centre
Altnagelvin Area Hospital
L'Derry BT47 6SD
Tel: 028 71 611449
Fax: 028 71 611272

Intravenous Fluid Management in Children/Young People (1 month old-16 years)

DATE: Tuesday 22nd November 2011

VENUE: Lecture Theatre 3, CEC
Altnagelvin Hospital

TIME: 1 - 4.30pm

Aim: to improve the knowledge of Registered Nurse (RN), in the management and care of a child/ young person (1 month- 16 years), requiring Intravenous (IV) fluid therapy in hospital

316-004f-022

RF - INQ

Intended Learning Outcomes

At the end of this session the RN should be able to:

- Discuss normal fluid balance and the importance of maintaining hydration in child/young person
- Consider fluid management in the perioperative child
- Discuss fluid imbalances and management of same in children, for e.g. dehydration, overhydration, hypernatraemia and hyponatraemia
- Discuss the importance of IV therapy and fluid requirements for the ill child
- Consider the risks of intravenous fluid therapy and importance of monitoring
-
- Understand, and be able to apply, the three modalities for giving IV fluids to children, depending on situation, eg fluid bolus, maintenance and deficit fluids
- Apply DHSS&PS /Trust guidelines & policies for the use of IV fluids in child/young person under 16 years
- Safely care for the child who in on IV therapy

You are encouraged to record your reflections on your learning using the NIPEC Development Framework Tool www.nipecdf.org

1pm	Introduction/Registration	***M Elliott***
1.05pm	Fluid Balance in Children – Physiology	***Dr Stewart***
1.30pm	Fluid Management in the Perioperative Child • DHSS&PS Guidelines (Nov2007) Re: 'Parenteral Fluid Therapy' • WHSCT (2008) Policy for prescribing IV Fluids to Children • WHSCT (2009) Fluid balance Chart for children	***Dr Stewart***
2pm	Fluid Imbalances in Children, e.g. Dehydration, Hyponatraemia	***Dr C Campbell***
2.30pm	BREAK	
2.45pm	Calculation of IV Fluid Deficit/ Maintenance/ Bolus Fluids, with group work/case studies	***Dr C Campbell***
3.45pm	Role of the Nurse in IV Fluid Management in children /young people	***M Elliott***
4.30pm	Evaluation and Close	***M Elliott***

316-004f-023

BC-0073-11

Point No. 6.3

RF - INQ

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Staff Nurse (Children's) Induction 7-day Programme- November 2011

Date Venue	Mon 14/11/11 LT 3	Tues 15/11/11 RR 4	Wed 16/11/11 LT 3	Mon 21/11/11 LT 3	Tues 22/11/11 LT3	Wed 23/11/11 LT 3	Thur 24/11/11 LT3
9.30	Welcome & Introduction to 7 day programme ***M Elliott*** Competency Development ***M Elliott***	Medicines administration to children ***M Elliott***	.30-10.15am Oxygen/Nebuliser Administration ***M Elliott*** 10.15-10.45am Oral & Nasal Suction ***M Elliott***	9.30-1pm Management of the Child with Epilepsy / Administration of Rescue medications ***M Mallon***	Pre & post operative care of child; Complications following surgery ***M Elliott***	Introduction to STAMP Nutrition tool ***M Elliott***	Safe Holding of Child ***J Christopher***
10.45	Break						
11.00 11.45	Child Development; Partnership working; Teams; Care planning ***M Elliott*** The sick child in hospital- common conditions/ ***M Elliott***	Paediatric Drug Calculations ***M Elliott***	Basic Life Support Infant & Child- (simulated practice) Care of choking child ***M Elliott& J Christopher***		Pain assessment & management in child ***M Elliott***	Care of child with Gastrostomy (plus work stations) ***M Elliott& J Christopher***	Safe moving and handling of children ***Robert Godfrey***
12.30	Lunch						
1.30 2.15	Legal & professional issues in caring for children: consent, confidentiality, record keeping ***M Elliott*** Safe guarding children and UNOCINI awareness ***M Elliott***	Drug calculations test ***M Elliott*** Anaphylaxis recognition and management ***M Elliott***	Nursing care of Child with Tracheostomy (plus work stations) ***M Elliott& J Christopher***	Haemovigilance – (Mandatory Training) ***Mary P Mc Nicholl*** 2.45 pm Break	1pm-2pm IV fluid Management in perioperative child ***Dr P Stewart*** 2.-3.30 Fluid imbalances; Calculation of IV fluids for children (with case studies) ***Dr Cathy Campbell***	Care of child with Nasogastric Tube (plus work stations) ***M Elliott& J Christopher***	
3.00	Break						
3.15 – 4.30		Anatomical & physiological differences in child /adult; Parameters of vital signs; Emergency formulas ***M Elliott***	Asthma Awareness ***Michaela Mc Auley***	3pm Infection prevention & control (Mandatory Training) ***Angela Thompson***	3.45-4.30 Role of nurse in IV fluid management ***M Elliott***		4.15 Evaluation of programme ***M Elliott/ R Godfrey***

316-004f-024

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DRAFT Care of the Child in Recovery

Dates/Times/Venue:

Dates of 2- day Programme:
Tuesday 6th December 2011 and Wednesday 7th December 2011

Time: 09.15-16.30

Venues: 6/12/11-Resource Room 2, Clinical Education Centre, Altnagelvin
07/12/11-Lecture Theatre 3, CEC Altnagelvin

Facilitators: Melanie Elliott & Anne Canning, NEDC

Aim:

This 2-day course will provide a background for registered general nurses working in theatre's recovery room, in the safe care of children in the immediate postoperative phase

Learning Outcomes:

The nurse caring for children in the immediate post-operative recovery phase will:

- Discuss how to meet the physical, social and psychological needs of the child in Recovery: Partnership with parents
- Describe the normal physiological parameters / vital signs in the child and how children differ from adults and appropriate action if abnormal
- Outline use of PREM system & relevant emergency formulas for use with children
- Recognise the key emergency risks & complications that may occur, e.g. shock & haemorrhage
- Discuss the principles of IV fluid management of the child
- Outline 'perioperative care of child policy' (Altnagelvin 2004)
- Discuss safe administration of medicines to children and undertake drug calculations efficiently
- Discuss approaches to pain assessment & management of the child
- Discuss principles of child protection and actions, if need indicated
- Describe the main features of handover of the child from recovery room to ward based nurse
- Consider legal and professional issues in caring for children
- Describe the appropriate action to take in emergency situations, particularly basic/advanced emergency airway management

CONTENT

Meeting Needs of Child
Introduction to Child development; Meeting physical, psychological and social needs of child in hospital; Communication with child & parents; Parental involvement & care of parents- partnership working and care-planning

Anatomical & Physiological differences in child/adult
Why children differ from adults; Normal parameters and monitoring of vital signs- temperature, pulse, blood pressure, SAO2, respiratory rate- Recognition of deviations from normal vital signs in children;
Useful paediatric formulas-W.E.T.F.A.G;
Introduction to PREM system (Paediatric Resuscitation &Emergency Management)

Potential complications of surgery
Early recognition and appropriate management of shock, haemorrhage, hypothermia, pain

Fluid management
Fluid management in the perioperative child; awareness of DHSSPSNI Guidance & Trust policies-

- DHSSPS Guidelines (Sept'07)-Parenteral fluid therapy
- WHSCT (2008) Policy for prescribing fluids to children
- WHSCT (2009) Fluid Balance Chart for children (1 month-16 yrs)

Medication Management
Review guidance and relevant Trust policies, e.g. WHSCT (2009) Medicines code-Interim Guidance; Safe administration of medicines to children; *Paediatric drug calculations & testing

*Nurses must demonstrate competence in paediatric drug calculations before the end of the 2-day programme

Legal and professional Issues in caring for child
NMC code /Records and record keeping/Accountability; Consent, Restraint, Trust policies and guidelines

Pain management
Assessment and management of pain –Pain Tools, WHO ladder; Appropriate choice of Analgesia-; Paediatric Drug calculations

Safe guarding children/Child protection
Awareness of principles of child protection/safe guarding children; Types of abuse -physical, emotional, sexual, bullying, domestic violence
Recognition of abuse & appropriate action-Assessment framework and referral-policies-role of nurse

Safe environment/Airway management
Recognise and manage airway problems;
Appropriate handover to ward nurse – documentation

You are encouraged to record your reflections on your learning using the NIPEC Development Framework Tool www.nipecdf.org

Day 1
Tuesday 6th December 2011 - RR2

09.15	Introduction to programme & Registration	*M Elliott*
09.20	Meeting physical, social and psychological needs of the child in partnership with parents/carers	*M Elliott*
09.50	Anatomical & physiological differences between child & adult; Normal parameters of vital signs	*M Elliott*
10.30	Coffee	
10.45	Useful paediatric emergency formulas (W.E.T.F.A.G.) Introduction to P.R.E.M. System	*M Elliott*
11.30	Legal and professional Issues in caring for children; Records and record keeping	*M Elliott*
12.15	Lunch	
13.00	IV Fluid management in the perioperative child	*Dr Patrick Stewart*
14.00	Altnagelvin Perioperative Policy (2004)	*M Elliott*
14.15	Administration of Medicines to children	*M Elliott*
15.00	Break	
15.15	Paediatric drug calculations	*M Elliott*
16.30	Evaluation/Close	*M Elliott*

Day 2

Wednesday 7th December 2011-LT3

09.15	Introduction & registration	*M Elliott*
09.20	Drug Calculations - Test	*M Elliott*
1 0.30	Coffee	
11.00	Assessment & management of Immediate Post- operative pain in child	*??June*
12.00	Child protection - basic awareness	*M Elliott*
13.00	Lunch	
13.45	Post-operative complications -Recognition & management (Shock/haemorrhage/hypothermia)	*A Canning*
14.45	Handover of child to Ward Nurse	? Shauna*A Canning*
15.15	Break	
15.30	Basic/advanced emergency airway management of child in Recovery	*? Dr J Doherty*
16.30	Evaluation & Close	*A Canning*

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Programme Facilitators

Melanie Elliott, Nurse Education Consultant, NEDC, CEC, Altnagelvin Hospital
Contact: [redacted] ext [redacted]
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Anne Canning, Education Manager, NEDC
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Other Programme Contributors

Dr Patrick Stewart, Consultant Anaesthetist, Altnagelvin Hospital
??Dr John Doherty, Consultant Anaesthetist, Altnagelvin Hospital

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Care of the Child/Young person in an Acute Hospital Setting

Dates: 2- day programme:
Tuesday 29th November 2011 and Thursday 1st December 2011

Time: 09.15 - 16.30

Venues:
29/11/11; Lecture Theatre 3, Clinical Education Centre, Altnagelvin
1/12/11: Resource Room 4, Clinical Education Centre, Altnagelvin

Facilitators: Melanie Elliott & Anne Canning

Aim:
This short 2-day course will provide a background for Registered General Nurses working in acute adult wards in the physical, psychological & social needs of the child

Intended Learning Outcomes
At the end of the programme, learners will be able to:

- Briefly outline the normal development of the child
- Discuss how to meet the physical, social and psychological needs of the child, in Partnership with parents
- Discuss how children differ from adults (parameters of vital signs etc), considering physiological response to illness and recognition of deterioration in condition
- Outline use of PREM system & relevant emergency formulas for use with children
- Discuss the role of the nurse in relation to administration of medicines to children in hospital and practice safe paediatric drug calculations
- Discuss Intravenous fluid management in children
- Review the professional and legal and responsibilities of the nurse in caring for the child
- Describe the basic principles of safeguarding/child protection
- Outline the approaches to pain assessment & management of the child in hospital

You are encouraged to record your reflections on your learning using the NIPEC Development Framework Tool www.nipecdf.org

Content

Meeting Needs of the Child
Introduction to Child development - physical, social and psychological aspects needs of child; Communication with child & parents; Parental involvement & care of parents- partnership working

Anatomical & Physiological differences in child/adult
How children differ from adults;
Monitoring of vital signs- temperature, pulse, blood pressure, SAO2, respiratory rate-Recognition of deviations from normal parameters of vital signs;
Recognising a sick child/deterioration in condition-Useful paediatric formulas- W.E.T.F.A.G; Introduction to Paediatric Resuscitation &Emergency Management

Administration of Medication/Drug Calculations
Review WHSCT (2009) Medicines code-Interim Guidance;
Safe administration of medicines to children,
*Paediatric drug calculations & testing
***Nurses must demonstrate competence in paediatric drug calculations before the end of the 2-day programme**

Intravenous Fluid management
Physiology of fluid balance; Fluid imbalances-hyponatraemia/dehydration; fluid management of child- DHSSPSNI Guidelines and Trust policies

- DHSSPSNI (Sept'07)-Paediatric Parenteral fluid therapy (Aged 1 month-16 years)
- WHSCT (2008) Policy for prescribing fluids to children
- WHSCT (2009) Paediatric Fluid balance chart

Calculation of bolus, maintenance and deficit fluids; Role of nurse

Legal & Professional issues in caring for children
NMC code /Records and record keeping/accountability; Consent, choice & decision-making; Parental responsibility; Restraint; Trust policies and guidelines

Child protection/Safeguarding children -basic awareness
Awareness of principles of child protection/safe guarding children;
Types of abuse -physical, emotional, sexual, bullying, domestic violence
Recognition of abuse & appropriate action-Assessment framework and referral and UNOCINI-policies-Role of nurse

Pain management in children
Assessment and management of pain -Pain Tools, WHO ladder;
Appropriate choice of Analgesia

Day 1: Tuesday 29th November 2011

09.15	Introduction to programme & Registration	*Melanie Elliott*
09.20	Meeting the physical, social, psychological care of the child; Child Development; Partnership working	*M Elliott*
10.15	COFFEE	
10.30	Administration of Medicines to children	*M Elliott*
11.15	Paediatric drug calculations	*M Elliott*
12.15	LUNCH	
13.00	IV Fluid management in the child	*Dr Patrick Stewart*
14.00	Fluid imbalances in children - Hyponatraemia, Dehydration	*Dr Cathy Campbell*
14.45	Calculation of Fluid deficit/Maintenance Fluids - Group work/Case Studies	*Dr Cathy Campbell*
15.30	BREAK	
15.45	Role of Nurse in Intravenous Therapy	*M Elliott*
16.30	Questions/Close	*M Elliott*

Day 2:Thursday 1st December 2011

09.15	Welcome back & Registration	*M Elliott*
09.20	Paediatric Drug calculations- test	*M Elliott*
10.15	COFFEE	
10.30	Anatomical & physiological differences between child & adult Normal parameters of vital signs Paediatric emergency formulas (W.E.T.F.A.G.) Introduction to P.R.E.M. System	*M Elliott*
11.30	Legal and professional Issues in Caring for children	*M Elliott*
12.30	LUNCH	
13.15	Safeguarding children and UNOCINI awareness	*M Elliott*
15.15	BREAK	
15.30	Pain assessment & management in children	*M Elliott*
16.30	Questions, Evaluation & Close	*M Elliott*

nedc
nursing education & development consortium, north & west

Programme Facilitators

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Programme Speakers

Melanie Elliott, Nurse Education Consultant, NEDC, Clinical Education Centre, Altnagelvin Hospital

Dr Patrick Stewart, Consultant Anaesthetist, Altnagelvin Hospital

Dr TBC, Paediatric Registrar, Altnagelvin Hospital

BC-0073-11

Point No. 3.1

POLICY FOR THE REPORTING OF CLINICAL INCIDENTS

February 2000

Introduction

Clinical governance is defined as 'a system through which NHS Organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish'.

Clinical Risk Management is an integral part of any Clinical Governance system and a key component of this is Clinical Incident Reporting .

Definition of a Clinical Incident

A clinical incident is a situation in which a patient is involved in an event which had a potential or actual adverse clinical outcome, which would not be expected to occur in the routine course of clinical events.

Clinical Incident Reporting

Clinical Incident reporting is first and foremost an opportunity to learn and to improve our practice and secondly it acts as *'an early warning'* of impending clinical negligence claims.

Clinical Incident reporting will aim to:

- reduce the occurrence of preventable adverse effects;
- minimise injury to patients;
- improve the quality of care for patients.

Clinical Incident Reporting enables clinicians or any member of staff to report a clinical incident which may or may not result in an adverse reaction for the patient being treated.

In an environment where staff feel secure and valued we want to encourage a culture of honesty and openness where mistakes and untoward incidents are identified quickly and dealt with in a positive and responsive way.

Procedure for Reporting Clinical Incidents

It is extremely important that any clinical incident should be reported on the appropriate documentation. Clinical Incidents must be reported immediately to the line manager and should be recorded using the relevant section in the Incident Book. All incident forms will be sent to the Risk Management Co-ordinator who will;

- Inform the Chief Executive/Medical Director/ Director of Nursing as appropriate;
- Contact all relevant staff and obtain detailed reports;
- Provide the Trust Board with details of trends.

Duties of employees

It is clear that the success of a Clinical Incident Reporting system will be dependent on staff participation. Clinical Staff are reminded of their professional accountability under their code of conduct for the standard of care they provide and implicit in that context is the responsibility to report clinical incidents.

Quality Improvement

Reviewing incidents will enable the Trust to pay particular attention to any deficiencies in procedures or practices which may have contributed to the incidents and will formulate directions and recommendations designed to eliminate or minimise the incidence of similar occurrences.

Signed Stella Burnside

Stella Burnside, Chief Executive

Policy to be reviewed in one year