

The Junior Doctor's Handbook

Altnagelvin Hospital
Health & Social Services Trust



No 11.

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 text-books.

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-being¹. 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. Acceptance 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 are expected to help cover ill or absent colleagues when locum cover can not be arranged.**

- 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 possession, 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.

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 being put in place to establish good practice in relation to health and safety systems and occupational health services for staff.

You are most strongly recommended to take advantage of your **immunisation update** call to the Occupational Health Department 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 are most strongly advised to seek medical assessment and treatment through the OHD (accident & emergency out of hours).

If you consider that your health is or may be affecting your work you should make contact with the OHD. You will be aware of your duties to seek the views of an occupational physician if you may be at risk of transmitting H.I.V to your patient.

Similarly work may be affecting your health, again confidential advice may be sought from the O.H physician. The most significant workplace difficulty experienced by medical practitioners in their initial years after qualification is depressed mood due to pressure on coping mechanisms from then challenges of work combined with social isolation. The consultant in Occupational Health welcomes contact from staff (at his office or at home, his current home telephone number is (01365 521650). Alternatively the B.M.A has established a counselling service for doctors (tel 0645 200169).

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! If a GP requests admission of a patient to the cardiac ward, the medical officer must ask if a cardiac ambulance is needed. If yes, the ambulance, the SHO covering will go to the scene with a CCU nurse. 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 admitted 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 PROCEDURE

Patient's Advocate

Complaints against doctors and other hospital staff are increasingly a fact of life. Sometimes there are 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. Be careful never to disclose confidential information without the patients written consent.

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.

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**. It is the responsibility of the surgical JHO to ensure that all emergency admissions to Surgical and Orthopaedic wards are examined and written up for medication. He/she must then contact the relevant SHO on call to see the patient. He/she must inform the doctor coming on duty the next morning of any problems.

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 (1996) 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 updated³.

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.

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. In all cases (Medical and Surgical), 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 will be as per contract:-

Specialist Registrars	6 weeks
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 Leave²

- **Induction course:** attendance at the induction course for Pre-Registration House Officers and other Junior Medical staff is **mandatory**. This is a requirement of the postgraduate council. PRHOs are also to be freed from clinical duties to attend the weekly educational forum.
- Study leave is granted at the discretion of the 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. There is a limited budget for study leave, so

full payment of expenses cannot be guaranteed. Apply early for the best chance of success.

- 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

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

“ In relation to leave outside NI, as a general rule SHOs should be provided with exam leave only. Specialist registrars are entitled to attend one to two UK meetings, and support will be considered at the discretion of the Director of the department 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.

Hospital Formulary⁵

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 acquaint 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 B₁₂ 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

This is usually the task of the consultant in charge of the patient. The patient who clearly requests accurate information regarding their diagnosis and prognosis has a right to be told the truth. Equally, patients who indicate that they do not wish to know their diagnosis or prognosis should have these wishes respected. There is never a good time to break bad news, but a sensitive approach is helpful. This involves speaking to the patient in a single room in the presence of another member of staff and a close relative. Avoid technical terms and repeat the most important information.

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

- **Form 3:** "Medical recommendation for admission for assessment", can be completed by a doctor on the **staff** of the General Hospital, as long as they have full GMC registration, if the patient's own **GP** is not available.

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.

PRESCRIBING⁵

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. Any known allergies must be clearly written on the front cover of the case notes and on the Drug Kardex.

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.

PRACTICAL ADVICE

Case note recording⁴

- 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. Avoid unapproved abbreviations, and above all avoid making derogatory comments about patients, relatives or other members of staff in the medical record.
- **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. Avoid personal comments.
- 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.
- All typed correspondence must be checked and signed by the doctor who dictates them.

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

- Diagnoses, with sufficient detail to permit accurate coding. (+Degree certainty)
- A concise summary of the reason for admission.
- History of drug reactions or allergies
- Significant findings on clinical examination
- The results of significant investigations (both positive and negative).
- Adverse inpatient events eg cardiopulmonary arrest
- Procedures, with sufficient detail to permit accurate coding
- Prognosis

- Therapy to be continued after discharge (dosage, frequency, proposed duration).
- 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 and/or community services arranged.

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.

Formal Detention Of A Patient In A General Hospital

- A patient can be formally detained if they are at **risk of serious self harm**, or have a mental illness and are **at 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 casenotes. 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 5:** "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. A Form 5 is not sufficient to transfer a patient to another hospital, i.e. if they require transfer to Gransha Hospital. **Forms 1 and 3** would be required before transfer.
- **Form 1:** "Application by the **nearest relative** for admission for assessment", is completed by the nearest relative. There are notes for guidance on who is the "nearest relative", on the reverse side of the form. If the next of kin is not available or does not wish to sign the form themselves, 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 they need detention.

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.

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 grief.

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 Guidelines⁶

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 Services⁶:

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 patient's 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"⁷. Appropriate 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 through 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	Paratyphoid Fever	Typhus
Diphtheria	Plague	Viral Haemorrhagic Fever
Dysentery	Poliomyelitis	Yellow Fever
	(Paralytic and Non-Paralytic)	
Food Poisoning (ALL sources)		Rabies
Gastro-enteritis (persons under 2 years of age only)		Rubella
Infectious Hepatitis	Relapsing Fever	
Lassa Fever	Scarlet Fever	

AIDS, 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 Patients Casenotes Standards

⁵ Hospital Formulary

⁶ Laboratory services Handbook

⁷ "Making The Best Use Of A Department Of Clinical Radiology"
Royal College of Radiologists booklet