Business Services Organisation

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

2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

Your Ref:	Our Ref:	Date:
AD-0499-13	HYPW50/1	4th February 2013

Ms A Dillon
Solicitor to the Inquiry
Inquiry into Hyponatraemia-related Deaths
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS- RAYCHEL FERGUSON

I refer to the above matter and to your letter dated 18th January 2013, reference as quoted above. My client responds to the bullet point questions contained in your letter, as follows (for your information, point 1 relates to the first bullet point, point 2 relates to the second bullet point, and so on):-

1. I am instructed that the Western Trust is not aware of such a written policy having been in existence in 2001.
2. Whilst the Trust has been unable to locate any specific guidance which would have been given to junior doctors in the surgical and anaesthetic teams regarding contacting consultants when children had been admitted out of hours, please refer to pages 11 and 12 (attached) of the Junior Doctors handbook for August 2001 which clarifies the rota and on call arrangements and the mechanisms for advice and support.
3. I am informed that there was no written guidance regarding the management of intravenous fluids in post-operative children, at the relevant time.
4. I am instructed by my client, as follows:-
   At that time, the Western Trust used a computerised Nursing Care Planning system known as 'DM Nurse'. This allowed Nurses to select care plans which had been approved through a nursing forum within the Trust and saved on the system. Nurses were responsible for individualising the care plan for the specific patient. Because it was a computerised system nurses would update the care plan/evaluation section once per shift to include the care throughout the shift for which they were responsible. A 'DM Nurse Project Group' was established to roll out the introduction and training of staff on this system. All nursing staff attended training on completing online care plans and evaluation. The Trust also had a

server which was backed up frequently to ensure that the data was maintained and saved. This system is no longer in use within the Trust.

5. My client informs me that it does not believe that there was a written policy in place in 2001 in respect of the supervision and management of post-operative children.

6. I am informed by my client that the former Altnagelvin Trust totally embraced the concept of family-centred care within the Children's Ward and the ethos of family centred care was embedded within the Unit. Moreover, a Philosophy of Care document had been prepared by the Ward and this was permanently displayed on the wall of Children's Ward. Please find attached a copy of same. In addition, all registered children's nurses would have been taught family-centred care throughout their nurse training.

7. My client has not been able to ascertain details of the information which would have been provided to surgical trainees in 2001, regarding operating on children at night. Regrettably, the Clinical Director for Surgery is now deceased and the Trust has been unable to ascertain, this far removed, who else within the Trust could provide information relevant to 2001.

8. My client has not been able to locate any specific guidance relating to junior doctors in the surgical and anaesthetic teams contacting consultants when children required surgery out of hours. Again, I refer to pages 11 and 12 from the Junior Doctors' Handbook for August 2001 which clarifies the rota and on call arrangements and the mechanisms for advice and support.

9. Whilst there was no written guidance, the practice was that parents could escort their child with the nursing staff to theatre and be present until the child was anaesthetised in the anaesthetic room. The Children's Ward nurse then advised the parents to go for a break and return to the Children's Ward to await the call from Recovery to say when the child would be ready to return to the ward.

10. My client has not been able to locate any written guidance in 2001 regarding the management of intravenous fluids in post-operative children. But, I refer to pages 20 and 21 of the Junior Doctors Handbook 2001 (attached) which provides advice on prescribing.

11. I am advised that there were different scenarios when a doctor would be called to see a child. Depending on the situation, a nurse may or may not have been present. If a child required an examination then the doctor would require a nurse to be present to chaperone, however, if a parent was present and a doctor did not need to examine the child, then a nurse may not have been present. It would have been expected that the doctor communicated his plan to one of the nursing staff after he saw a patient.

12. Please see response at Number 4 above.

You will note that we have previously sent you copy relevant extracts from the Children's Ward Treatment Book for Ward 6, on 23rd January 2012.

I am also informed by my Client that, despite extensive searches, neither the Surgical nor Paediatric Rotas for 7th to 9th June 2001 (inclusive), can be found.

I await receipt of the Nursing Off-Duty Rotas for Ward 6, in connection with your request reference AD-0492-13, and I shall forward same to you, directly upon receipt.

Yours faithfully

AN Crawford

Angela Crawford
Solicitor

NURSING PHILOSOPHY

The nursing philosophy of Ward 6 is to:

1. Provide the child and family with skilled, researched, individualised nursing care. This will be done by practising the Nursing Process and using a Model of Nursing in order to meet the child's individual needs - physical, psychological, social, cultural and spiritual. Remember that each child is unique.

2. Provide a holistic framework for nursing care.

3. Respect the child's dignity and privacy at all times.

4. Ensure confidentiality at all times.

5. Provide the optimum environment for recovery, promoting a restful and peaceful atmosphere, and adapting organisational routines to the child and parents usual life-style, insofar as it is possible to do so.

6. Provide stimulation for the child through play therapy, which is adapted to the age and understanding of the child.

7. Respect the parents' right to freedom of choice, providing sufficient information and education to enable them to make that choice. Listen to children and attempt to understand their perspective and opinions. According to age and understanding, involve participation of the child in decisions about care in accordance with the PATIENTS CHARTER.

8. Use opportunities for health education of parents and their families.

9. Encourage parental involvement in care of children insofar as it is appropriate. Continue to work to identify trends which may threaten the health/well being of children.

10. Liaise with the multi-disciplinary team to ensure safe return of the child into the community.

11. Where necessary, mobilise community resources to assist the patient's return into the community and to facilitate their continuing recovery. Advocate the aim of the reduction of hospital admission and inpatient stay by promoting family participation in care, day services and community nursing services.

12. Ensure the safety of children and their families.

13. Ensure that resources are carefully used to the patient's benefit.

14. Maintain and monitor parents satisfaction with the care delivered.

15. Ensure that an open visiting policy is encouraged for parents and that relatives and visitors are received in a courteous manner. Information relating to the child's diagnosis and/or condition should be discussed only with their parents or legal guardian.

16. Limited accommodation is provided for parents in the ward environment

17. Where recovery is not a feasible goal for a child then promote a
allows them to die peacefully and with dignity, giving the emotional
support both the child and parents require.

18. Ensure that other relatives of terminally ill children are given the emotional
require. In these circumstances, visiting arrangements should be flexible, wi
into account the needs of the child as well as those of the family.

19. Ensure that nursing care adheres to the policies and procedures accepted with the Wester
Health and Social Services Board and also the Children Act, European Charter and Action
for Sick Children.

The Altnagelvin Doctor's Handbook

Altnagelvin HSS Trust

August 2001

ROTA AND ON-CALL ARRANGEMENTS

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

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

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

Pre-Registration House Officers

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

Medical Senior House Officers

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

Medical Specialist Registrars

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

Three tier cover rota (SHO, Reg, Cons)

A & E, Anaesthetics, Obs & Gynae, Paediatrics.

Ophthalmology & ENT (Shared SHO).

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

Orthopaedics, Surgery

Medicine (with two teams of SHOs)

HOSPITAL ORGANISATION

Major Emergency Plan[7]

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

ORDERCOMS (OCM)

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

Admission policies[8,9,10]

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

The **medical** allocation system is rather more complicated! Patients of all ages with definite or suspected acute myocardial infarction, or unstable arrhythmias, are admitted directly to the ***coronary care unit (CCU)***. Severely ill patients with LVF may also be admitted to CCU. Patients with other cardiac problems are generally

Please don't forget to fill out the incident forms so that management can better identify problem areas.

Some useful recommendations are as follows:

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

Prescribing[11,12]

Prescribing medication is one of the most important duties as a junior doctor, and mistakes in this area can be disastrous for the patient. There can be major medico-legal consequences, and if you do not take care in prescribing you may cause harm or lay yourself open to litigation. The following general guidelines may help, but remember to ask a senior colleague and consult the British National Formulary (BNF) if you are in doubt.

Accurate and safe prescribing[11]

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

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

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

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

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

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

(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. You may also wish to ask the advice of the Pharmacy department who can research the literature on side effects and interactions of new or less commonly used drugs. Always record the reasons for initiating therapy in the medical notes and inform the nursing staff. Inform the General practitioner of these indications and of how long you intend the patient to take the medication. The patient should also be fully informed about their medication, and where the drug is

particularly toxic, you should provide specific patient information and record that you have done so.

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

Adverse reactions

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

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

Hospital Formulary[12]

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

Medication on Discharge

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

Anti-Coagulation

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

Pharmacy: A valuable Information service

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

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