HSC Business Services Organisation

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

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Your Ref: Our Ref: Date:
25th June 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 have been passed some documentation by the Western Trust which relates to the Raychel Ferguson case. I now enclose the following for your attention:-

1. Letter dated 29th June 2000 – S/N McKenna to Mrs Doherty
2. Letter dated 3rd February 2001 – S/N McKenna to Mrs Doherty
3. Letter dated 1st June 2001 – S/N McKenna to Mrs Doherty
4. Audit of Dependency Levels and Review of Staffing Establishment within the Children's Ward.

I am instructed that Mrs Margaret Doherty, who no longer works for the Trust, requested a senior member of Trust staff to look for documentation to assist her with completion of her witness statement. The member of staff found the enclosed documentation in an old cabinet which had been in use while Mrs Doherty worked for the Trust.

The Trust apologies for the late submission of this document to the Inquiry.

Yours faithfully

JR Bolton

Joanna Bolton
Solicitor Consultant

MMcK

S/N Mary McKenna
Children's Unit

29th June 2000

Mrs M Doherty
Clinical Services Manager
Women & Children's Care Directorate

Mrs Doherty,

Further to our discussion on the difficulties we are experiencing at present in providing adequate cover on the ward, I wish to make you aware about the number of patients ventilated and transferred from Altnagelvin to the Royal Children's Hospital.

In 1996 -97 we had approximately 12 patients transferred ventilated. The following year we had approximately 15. Over this last year we have been transferring on average 1 -2 per month, i.e. approximately 20 in the year (minimum). Children are being ventilated prior to transfer now, (before the situation has become one of 'resuscitation'). Those patients identified as life threatening are now often ventilated and transferred for further management, as per guidelines laid down for our medical colleagues. Such guidelines can be seen from the Advanced Paediatric Life Society.

These ventilated patients are sent from both Ward 6 and the Accident & Emergency Department, where a Children's Nurse is requested as the escort. However, when this Staff Nurse leaves the ward, it often depletes the ward staff for an average of 4 hours.

It would appear an ideal opportunity if we could offer our staff a period of time in N.N.I.C.U for ventilator experience. However, in order to do so, we would need to replace these staff on the ward whilst they are out on rotation.

As you are also aware, there are times when our workload is stretched by accommodating patients from ENT and Oral Surgery when Ward 10 closes, or has a shortage of children's spaces. We also have children on the ward under the care of Dr Dickey (gastro-enterologist) and Mr Lennon (Urology).

There are often times when patients are admitted to Ward 6 who would be admitted to High Dependency Unit or Intensive Care Unit if they were in the Children's Hospital or another District General Hospital.

These patients include serious asthmatics, bad head injuries, and some toxic ingestions. These patients ideally need specialed , but often this is not practiced, which we have concerns about.

There has also been an increase in the number of patients with life-limiting illnesses surviving over the last 12-18 months, who require a lot of nursing care and are presently long-term on Ward 6.

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Now on reflection of the past few years since the amalgamation of Ward 6 and Infant Area, we can see an increase in the workload and in the volume of patients.

We now feel we need to address the problem of staffing levels on the ward and reach a solution.

Yours sincerely,

STAFF NURSE MARY MCKENNA
WARD 6

MMcK

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST
ALTNAGELVIN AREA HOSPITAL
PAEDIATRIC DEPARTMENT
LONDONDERRY BT47 6 SB
TELEPHONE - [redacted]
FAX - [redacted]

3 February 2001

Mrs M Doherty
Clinical Services Manager
Women + Children's Directorate
Altnagelvin Area Hospital
LONDONDERRY

Dear Mrs Doherty

I want to put in writing today (Saturday 3 February 2001), the situation as it is in Ward 6.

There were 8 trained staff this morning and 7 for the afternoon and evening.

At 8.00am I had 29 patients in total on the Ward, 10 of those were in the Infant Area, with 4 of those in oxygen, 1 being "specialed" and 3 needing close observation. Six of those patients were on monitors and 2 were receiving tube feeds.

On the main ward we had 19 patients with one patient very ill, needing "specialed".

After contacting Sister Donaghy this morning I received help, a Staff Nurse from Ward 5, who was very willing and helpful, yet inexperienced in caring for very ill children. Throughout the course of the day we had admissions and discharges, and staff were often inconvenienced and had to cut their meal breaks short.

I spent 1 ½ hours of my time this morning getting a 6th Staff Nurse to cover tonight and tomorrow night because of unexpected sick leave, and in view of the number of very ill children on the ward needing close observation and "specialing", and still trying to have staff available for the situation that might arise, eg a transfer, numerous admissions.

This evening I had a phone call from a recently discharged post liver transplant patient, and I spent 1 hour phoning doctors, pharmacists, finding notes etc to sort out a medication problem that the mother had. Again this reflects what happens regularly here; time out is taken to facilitate ward attenders out of hours or children with open access who need assessment and advice.

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This situation today is not unique. It appears to be a repetitive cycle of events on the Children's Ward over the last number of weeks and months. The morale of staff is falling as staff are mentally and physically exhausted, many from working extra hours and they are now frustrated at little apparent improvement in the staffing situation.

This Ward is usually divided into 4 areas, yet some days it is divided into 3, with one trained member of staff being the named nurse for more than 8 patients, and possibly up to 14. We feel this ridicules the ethos of holistic care, and we find that we are practicing task orientated care. We are now meeting this challenge annually, and we have brought our concerns forward before by writing, but unfortunately we have not found solutions, and yet we are faced with repeated situation time and time again.

I appreciate that you are equally as frustrated as we are, but we are now at the situation where we feel things may be unsafe, and staff find it very difficult to cope with the condition in which we are finding ourselves at present.

We would appreciate it if you would bring our concerns forward to Miss Duddy and Mrs Burnside.

Yours sincerely,

Mary McKenna SEN.
E. J. Millar.

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HMcK

1st June 2001.

Dear Mrs Doherty,

I wish to make you aware of the difficulties and difficulties experienced recently when we have been in need of help on an immediate basis.

On 18th May ,I came on duty in the afternoon as I had been to a meeting in Antrim in the morning. Miss Gillen had asked the staff in the morning not to cancel our nurse that night as we has originally planned as our numbers were less than 20.However within 2 hours of my coming on duty we had 8 admissions, so I contacted SR Donaghy in NNICU to inform her that I would probably be unable to give her my 5th nurse that night. Throughout the evening we negotiated and reached a compromise, which was that my nurse would do a transfer from approx. 8pm-11.30pm from the NNICU, and that she was to return to WD 6 for the remainder of the night. Unfortunately she did not return as WD 6 subsequently had a transfer later in the night, with the result of the staff not getting their breaks and the ward being scarcely covered.

My second episode recently occurred on the 27th May. We had a minimum number of staff on day duty due to 2 staff off sick. SR Fitzsimmons was in contact with the ward as we were short of staff and I told her I would call her if I experienced problems. In the evening we had a new patient for urgent CT.scan, and at approx. 7.35pm we had a phonecall from the husband of S/n Doherty who was due on duty,to say that their child had taken suddenly ill.(She had an anaphylactic reaction).S/N Doherty obviously had to go to her daughter at Letterkenny Hospital. I phoned SR Fitzsimmons at this stage to inform her of the new dilemma, as the patient was going to CT at 7.45pm.and needed accompanied with a trained nurse. SR Fitzsimmons informed me that there was only one patient in labour ward and that she would ask the co-ordinator to help us out. An auxiliary nurse was sent to the ward ,because midwives will not come to the children's ward because of ?potential infection risk. Why is it then that Sho's,Registrars and consultants all can run between these units without the same risk? I have previously worked in another hospital and frequently would have gone between the children's ward and the special care unit to help when either unit was short of staff. I know that SR Fitzsimmons also was frustrated with the reluctance amongst midwives to move to our unit when an immediate need arises. I have left word with Mrs.F.Hughes (Infection Control Nurse) to see if can give me any supporting evidence either for midwives to move or not ,when this problem will inevitably occur again in the near future. In the meantime I want to ask that you give this matter some consideration, and perhaps we could discuss it further at Sr's meeting forum, after we have got some more facts on the subject.

Yours sincerely

Mary Mc Kenna.

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AUDIT OF DEPENDENCY LEVELS

AND

REVIEW OF STAFFING ESTABLISHMENT

WITHIN THE CHILDREN'S WARD

(OMITTING DAY CARE UNIT AND CLINICS)

The reason we decided to look at the staffing levels within our Ward was as a result of discussions on staffing level comparisons, both within our hospital and province-wide.

We also wanted to find out if activity was actually increasing within our ward. Attendance appeared to be increasing, and we thought this may be a reflection of the increasing population within our local area.

There is no known dependency tool for assessing children's needs. The 'criterion for care' took is now in use for 10 years and was not designed for the care of children. We feel it is not a suitable tool to be used within our Department. We think there is no suitable tool available to determine paediatric dependency levels, which would determine staffing establishment and skill mix to provide the care needed within our department.

Our unit is very different from all other children's wards within Northern Ireland's District General Hospitals. We are unique in that we have 43 beds/cot spaces being accommodated on one ward. Our patients are medical, surgical, othopaedic, infant care and a small number of urology. We also accommodate E.N.T. and Oral Surgery when Ward 10 is closed, or if the child is very young.

We devised a method of data collection suitable for our area and following a trail year of collating information, it was decided that we needed an in-dept audit to be carried out over a three month period. The form that we used at ward level to gather this data daily is shown as **Appendix A**. This does not include duties carried out by Nursing Auxiliaries within our Department and only pertains to duties of qualified staff.

At the end of the three month period, we asked the Statistics Department to demonstrate on graph our findings. **See Appendix B**

Certain activities and processes are combined in order to allow presentation. The data is averaged over a 90 day study to indicate a staffing day in terms of hours.

The figures are a basic overview of the activities of the normal day to day in the Children's Ward. It does not take into account:

- Emergencies.
- Care of critically ill patients. (There were 3 patients ventilated during this period, however it has not been possible to demonstrate this in our audit.)
- Specialing a patient on a 1 - 1.
- Attending to the ward attenders who are seen between 5.00 pm - 9.00 am, at weekends or on bank holidays.
- The time lost when a member of staff is accompanying a patient to another Hospital. (Six hours on average per episode)

AUDIT OF ACTIVITY ON THE CHILDREN'S WARD

We have selected months December '00, January '01 and February 01 for our audit, and plan to show the average activity performed by trained staff on the Children's Unit.

The mean average of patients was 28 per day for the period chosen. The average number of admissions was 11 per day for the period chosen, however there were days when admission numbers were 20 and this audit may not reflect the activity on those days.

The average number of staff on duty is 9/8/7 Monday - Friday and 8/7/7 at weekends, and 5 trained staff at night, ie. 13 Staff Nurses x 10 hours 35 minutes on 5 days = 137 hours 35 minutes (Monday - Friday) or 131 hours (Saturday - Sunday) available of nursing time in a 24 hour period.

Nursing time available = mean average of 135 hours 43 minutes per day.

The following are a list of what we feel are trained staff responsibilities, however there are many more not included which should be given consideration when the need arises.

- Accompanying Doctors on ward rounds. = 6 hrs per day

- Checking of medications (2 Nurses in children's), 5 medicine rounds. + home leaves + prn medications + preparing and administering IV antibiotics. = 15 hrs per day

- Check emergency trolley, equipment bag (daily - 15 mins and weekly full check takes 2 hours) = average per day 30 mins

- Handover report in morning and evening, average length 30 mins (9 Nurses present receiving the report from S/N of previous shift in the morning and 5 Nurses getting report from S/N at night.) Infant area and main ward give separate reports, therefore always at least 2 Nurses handover. = 9 hours

- Informing staff after morning report of any new policies, practices, etc (9 staff) approx. 10 mins duration = 1 hr 30 mins

- Updating careplans; average 20 minutes per patient x twice daily (day and night) = 18 hrs 40 mins

- Education of patient and parent, 1 hour per patient = 28 hours per day

- Liaising with other Departments either by phone or computer (at least 14 patients per day) eg. Physio, Dieticians, ECG, X-Ray, Ambulance, etc., average 10 minutes each episode. = 2 hrs 20 mins

- Reassuring patients/parents. Answering queries from grandparents. Resolving potential complaints. It may take 4 Nurses to reassure one mother. Another mother may have got bad news and need a Nurse for many hours. In terminally ill patients the Nurse may

need to stay constantly with the parents. (One hour/ patient/day) = 28 hrs

- Wound dressings (average 2 per day) - 25 minutes each. = 50 mins
- Ordering of pharmacy (weekend 2 hours, daily 20 mins = 30 mins
- Admissions (average 11 per day, 60 minutes each). This is time taken to gather information and store same on computer. It is not time taken to reassure distraught parents or patients. = 11 hours
- Discharge (average 11.6 per day, 18 mins each). = 3 hrs 18 mins
- Tube feeds (average 3 patients per day x 5 feeds), approx. 20 minutes per feed. = 5 hours
- Checking up on blood results or x-rays and acting on any that need attention (average 10 patients per day, 10 minutes each). = 1 hr 40 mins
- Average 4.6 patients on IV fluids per day, needing site, rate and chamber checked every hour and their chart completed (average 3 minutes per patient, if no complications). = 5 hrs 30 mins
- Post op observations (average 1.5 patients/day, 1/4 hourly for first hour, 1/2 hourly for second hour, one hourly for next 4 hours = 18 sets of observations (approx. 8 minutes). = 2 hrs 24 mins
- Taking patient to and from Theatre (1.5 patient/day, 26 minutes average each time). = 78 mins
- Attending to patients on oxygen, giving holistic nursing care. These patients are very closely observed by nursing staff, needing monitors calibrated regularly, requiring regular observation of vital signs (average 3.7 patients on oxygen, needing about 8 hours

each of nursing care/day). = 29 hrs 36 mins

- Making out off duty, amending same and getting cover when staff are sick = average 40 mins/day

TOTAL = 170 hrs 26 mins

STAFFING ESTABLISHMENT DISCREPANCIES

Nursing Time Required Per Day (Pages 5, 6 and 7) = 170 hrs 26 mins

Nursing Time Available Per Day (Appendix B) = 135 hrs 45 mins

Variance Per Day = - 24 hrs 43 mins

x 7 days

= 173 hrs 1 min

÷37.5 hrs or 1 WTE

= 4.0 WTE qualified staff

Therefore 4.0 WTE are required over and above the present staffing levels to maintain services

There has been no allowance made within these times documented for staff to take their normal break, which is known as a good will break. There is also no time built in for staffs personal needs, eg. to go to the toilet.

As there is no dependency scoring system in children's nursing, it can be very difficult to explain on paper the different needs of each individual patient. Often we have patients on our unit, who ideally would be nursed in an Intensive Care Unit or High Dependency Unit, but as we are a District General Hospital we need to accommodate these children on our Ward to ensure that they get the expertise of the Children's Nurses and the Paediatric Medical Staff. Some examples of these patients are those in status epilepticus, serious-life threatening asthma, biochemistry imbalance, head injuries and trauma cases to mention a few.

Over the last four years, Sr Millar has had an increase in her ward management responsibility and is now responsible for:

- Ward Budget
- Education Budget
- Managing Absenteeism
- Individual Performance Reviews (I.P.R.)
- Interviewing of staff while on sick leave and occupational health referrals
- Formal interviewing
- Dealing with complaints and adverse incidents
- Development of Day Case Unit, Clinics on Ward 16, and Paediatric Ambulatory Care.

However, Sr is still included in the staff numbers as being available to deliver clinical care to the patients.

With clinical governance, we recognise the need for staff education and development. We also want to be able to develop standards and frameworks at ward level to enhance clinical risk assessment, clinical supervision, research and clinical audit.

However, there is no time in the average day for any of the following:

- Staff education
- Quality issues, eg. ward standards and audits
- Care pathways
- Clinical supervision
- Student Nurse Education/preceptorship on a formal basis
- Attend meetings, eg. Link Nurse Meetings for Wound Care Nurses, Infection Control Link Nurse and Diabetic Link Nurse
- Curriculum Planning Meetings
- Queens Partnership Meetings
- NI Paediatric Benchmarking Meetings
- Professional Development Meetings
- Case discussions on patients
- Discharge Planning Meetings for those patients with more complex needs
- Sisters Meetings
- IPR sessions between Sister and staff
- Ward Meetings
- Consultant Meetings
- Strategic Planning Meetings

From this information given, you can see the great difficulties and frustrations that the staff of the Children's Ward experience due to the shortfall in qualified nursing manpower.

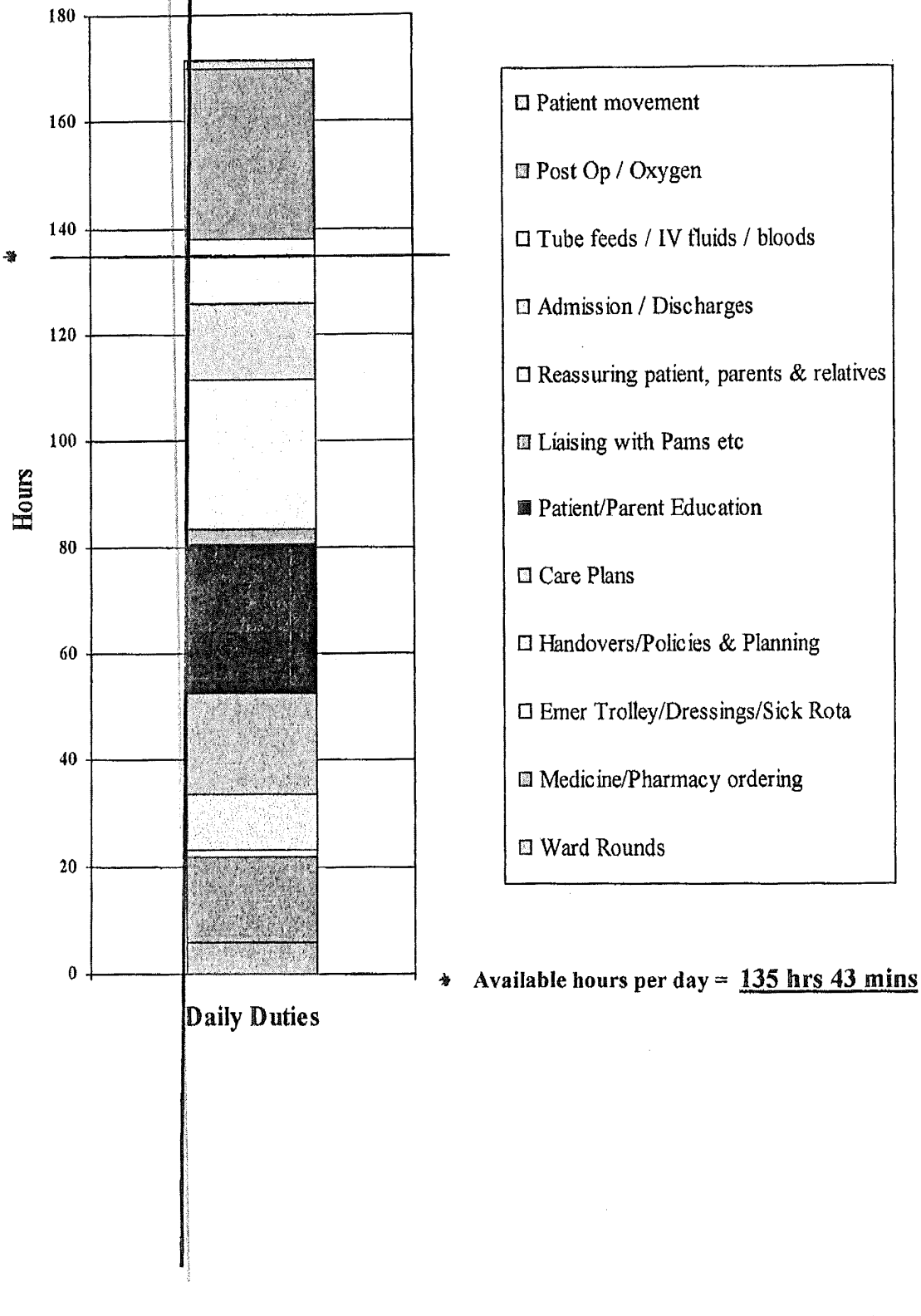
As mentioned earlier, Altnagelvins Children's Ward is unique, in the variety of patients that are cared for within it. Hence, the reason why we carried out this in-depth audit of dependency level within our ward.

APPENDIX A

PLEASE RECORD AT THE END OF EACH SHIFT

No. of Patients at 8.00am **Date**	**Area** - State main ward or G-H)	
	Day	**Night**
Number of Admissions		
Number of Discharges		
Number of Patients on IV Fluids		
Number of Patients on IV Antibiotics		
Number of Patients on Monitor		
Number of Patients Needing Hourly, Pressure Area Care (ie. Turns/Ring Care if in Traction)		
Number of Theatre Patients		
Number of Patients on Oxygen Therapy		
Number of Patients on Tube Feeds/Peg Feeds		
Number of Patients Needing Spinal Care		
Number of Patients Escorted to X-Ray or Out-Patients		
Number of Patients under 3 years of age		
Number of Wound Dressings		
Number of Patients with Tracheostomy		
Number of Patients Needing Specialed (consider bad head injury, bad asthmatics, status epileptics, etc)		
Number of Patients attending as Ward Attenders or Out-Patients. How long taken with each - state times (eg. 20 mins)		
Number of Patients Transferred to another Hospital or attending another Hospital for investigations		
Is the Ward down any Beds		

Childrens Ward
Nursing hours per day



* **Available hours per day = 135 hrs 43 mins**