HSC Business Services Organisation

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

2 Franklin Street, Belfast, BT2 8DQ
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Your Ref:
BC-0210-13

Our Ref:
HYP W50/03

Date:
15th August 2013

Mrs Conlon
Secretary 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 of 2nd August 2013.

I now enclose copy Clinical Audit Report 1999/2001 in respect of Altnagelvin Area Hospital as requested.

I trust that this is in order.

Yours faithfully

JRBolton

Joanna Bolton
Solicitor Consultant

ALTNAGELVIN HOSPITALS H&SS TRUST
ALTNAGELVIN AREA HOSPITAL

CLINICAL AUDIT REPORT

1999/2001

DOCUMENTATION AUDIT

Nursing Records

12 questions asked

8 questions scored below 80% compliance

None achieved 100%

Medical Records

14 questions asked (7 questions had more than one section)

6 scored less than 80% in overall score

5 questions scored below 80% in "sections"

Pharmacy Records

10 questions asked (8 questions more than one section)

7 questions scored less than 80% compliance

Discharge Information

1. Is the (a) discharge summary and (b) dictated letter filed in the patient notes ?
   (210 patient records audited)

   Summary 75%
   Letter 85%

2. When the patient is discharged, is the discharge note legible?

   86% were legible

3. When the patient is discharged on medication, has the medication been fully transcribed from the medicine kardex to the discharge summary ?

   a minimum of 25% of patients

Key Issues from Nursing Audit

Question 1 Manual Handling

Is there a moving and handling assessment completed ?

Implications:

This is a Legal Assessment for all patients admitted
(Manual Handling Reg 1992).
Failure to complete a moving and handling assessment on the patient increases the risk of inappropriate handling of patients and an increase in staff injures occurring .

Compliance:

Overall was 7 1%
(was as low as 67% in one directorate and as low as 0% in one ward).

Question 2 & 2b Named Nurse

Is there a "named nurse" for the patient ?
How much input to the patients care does the named nurse have:

The Patient Charter states that the patient should be allocated a named nurse who will have a major input into their care.

Compliance:

83% of patients appeared to be allocated a named nurse on admission with 84% of these patients having almost no contact with their named nurse during their hospital stay.

Question 4a Armbands

Has an identity armband been placed on the patient on admission?

Implication:

There is a major risk management and patient safety issue when identity armbands are not issued to patients.
The identity armband has an unique patient hospital number which is often the only marker to identify patients who possibly have the same name/DOB/or address .

Note: The identity armband is vital in relation to identification of the deceased patient in the mortuary.

Compliance:

Overall the compliance was 87%

(1 ward currently does not use patient identity armbands - they need to find a method of identifying patients)

Question 5 Individualised Care Planning

Has careplan been individualised ?

A extensive bank of patient careplans are available to Nursing Staff to select the appropriate interventions that may be required for their patients .

For example while the bank of information will indicate a wide range of observations not all are appropriate to each patient.
The audit highlighted that whilst many interventions are allocated they are not patient specific

ie observations to be carried out 2 hrly, 4 hrly, 6 hrly .

This is not clear to the reader what should be done and increases the risk of a patient being over or under observed .

Compliance:

44% compliance and as low as 27%.

Question 6 Reviewing Care During Stay

Is there any evidence that the care plans are reviewed (ie care added and deleted during stay) ?

During an inpatient episode as a patient's condition changes, careplanning should reflect this.
The audit identified that a patient could begin and end their hospitalisation appearing to have the same clinical problems and issues present with no progress being made.

Compliance:

55% of careplans were reviewed and updated
(was as low as 39% in one directorate).

' The careplan is the legal document that is referred to address complaints and incidents '

Question 9 Abbreviations

If abbreviations used are they within the agreed list?

In Altnagelvin there is an agreed list of nursing abbreviations.

There are many abbreviations in use that are not on the original agreed list.

Compliance:

26% compliance

Action:

Update current list and where appropriate add on new items.

Question 11 Patients Education On Discharge

Is there any evidence of patient education/information on discharge?

Compliance:

34% of patient records indicated that patients received some form of education/information on discharge.

Key Issues from Medical Records Audit

Question 1 Name, Hospital Number and Date of Birth on all records pertaining to the episode of care audited

Is the patients Name, Hospital Number and DOB on all records?

Compliance:

62%

Question 2b Allergies at Front of Notes

Are any known allergies clearly written on the front cover?

Where a patient has a known allergy to a drug or medical device, it should be written clearly on the front of the patient notes.

Compliance:

58 patients were found to have allergies listed in the body of their notes
BUT only 9 patients (16%) had it recorded on the front of their notes.

Question 3 Left and Right in Full

Are "Left" and "Right" written in full ?

Implications:

Risk management - potential for wrong limb/ eye/ ear to receive incorrect treatment .

Compliance:

132 patients were identified as having Right or Left referred to in their charts BUT only 11 (8%) had it written in full.

Question 8 Consent for Surgery - Legibility

If the patient consented for a procedure is the following on the consent form ?

Procedure legible = 49%

Signature of Doctor legible = 86%

Question 9 Frequency of Medical Entries

During this episode of stay how frequently was a medical entry made in the patients notes?

57% of patients had a daily entry in their medical records (Monday - Friday)
16% of patients had an entry on alternate days in their medical records.
8% of patients had an entry every third day in their medical records
The remaining 18% of patients had an entry less than every three days in their medical records

Entry less than 3 days =18%

Large gaps in some patient's notes. May be reflective in the clinical activity of the area.

? acceptable for patients occupying acute admissions beds not to be seen daily by medical officer.

Question 10a Time of Entry

Is the date and time of every note shown ?

Date = overall 96% compliance
Time = overall 8% compliance

Question 10b

Was the name and grade of staff printed out beneath the signature ?

Name printed = 4%
Grade of staff = 11%

Question 12 + 13

If the patient had surgery is the following on operation and anaesthetic notes:
Patients full name, DOB & Hospital Number: are notes legible
is the name of procedure legible: is the record signed ?

Name, D.O.B., Hosp No; = 90% on operation notes
= 74% on Anaesthetic chart

Operation Notes: Notes legibility = 42%
Name of procedure legible = 59%

Anaesthetic notes: Notes legibility = 42%
Name of procedure legible = 55%

Question 14 Drugs during Surgery

If the patient had surgery and if drugs have been administered have these been written (a) legibly, (b) stating the dose, and (c) stating the route?

Legible = 40%
Dose clear = 60%
Route drugs = 25%

Key Issues for Pharmacy

Question 1 Medicine Kardex

Is the following on the medicine Kardex ?

Name = 99%
D.O.B. = 88%
Hosp No = 97%
Weight recorded = 10%

Question 2 Allergies Recorded

Has the section "allergies" been completed ?

55% completed correctly with either "Yes" or "None Known".

Question 3a Block Capitals

Are all prescriptions written in (a) black and (b) block capitals?

Black ink = 74% compliance
Block Caps = 42%

Question 4a

Is each prescription individually (a) signed in full and (b) dated?

Signed in full = 72%
Dated = 82%

Question 5a

Do PRN drugs have a "specific timeframe/maximum dose" ?

Timeframe recorded = 15%

Maximum dose = 38%

Question 5b

If the patient was on antibiotics was there a "length of treatment" included on the Kardex ?

Of the 53 patients on antibiotics only 11% had a length of time documented.

Question 6

Do any cancellations have : a straight line, discontinuation initial and date ?

(91 patients in the audit had drugs discontinued)

Straight line = 92%

Discontinuation Initial = 62%

Discontinued date = 59%.

Question 10 Administration record

Has the last record of administration sheet been filled in showing all drugs prescribed either being given at the correct times or, if not, being given at the correct times with a corresponding reason for non-administration ?

74/154 (48%) patients had appropriate documentation