Healthcare Associated Infections

"Never Do Harm To Anyone"

Hippocrates 4th Century BC

HCAI are a PREVENTABLE cause of illness, misery and even death. As a doctor, you have a duty to protect your patients from HCAI. Average rates of HACI vary from 15-30 % but experts say that ALL cases are avoidable.

HCAI include

- Staph Aureus /MRSA
- C Difficle Associated Diarrhoea
- Norovirus Gastroenteritis
- Extended Spectrum Beta Lactamase Producing Organisms (eg coliforms)
- Glycopeptide-resistant enterococci
- Blood Borne Virus Infections

THE THREE PILLARS OF HCAI PREVENTION ARE
1. HAND HYGEINE
2. ENVIRONMENTAL CLEANLINESS
3. EFFECTIVE PRESCRIBING

- Wash or cleanse you hands thoroughly* between patients – and be seen doing it!
- Use the correct gloves, aprons etc for the type of procedure you are undertaking and dispose of these properly
- If you see blood spills, contaminated equipment etc, alert nursing staff but where possible clean up after yourself. Maintaining a clean environment is EVERYONE'S business
- Dispose of sharps and other clinical waste safely
- Adhere to the Trust's Guidelines on Empiric Antibiotic Prescribing for Secondary Care (on PC desktops)
- Do not prescribe unnecessary or "routine" proton pump inhibitors; they predispose to CDAD
- If you have an infectious disease do not expose patients or colleagues to the infection
- Be vigilant about admitting patients with a potential infection risk to general wards
- Only insert venflons if appropriate and using a clean technique

***When washing your hands, your forearms should be completely bare – no watches, sleeves etc- use the standardised "seven step" method to ensure all surfaces of your hands are cleaned and, for assurance and reassurance, make sure that whenever possible you are seen doing this by patients and colleagues**

Communication

The General Medical Council has emphasised that doctors have a responsibility to communicate properly with patients and with other doctors. This department prides itself on good communication.

This section covers

Clinical Notes
Contacting GPs
Referring patients to other hospitals
Handing over patients to ward doctors
Taking telephone enquiries
Mobile phone calls from ambulance crews
(use of computerised records are described in the Symphony handbook)

Clinical Notes

- ***"your writing must be legible!"***

Record:

- ***your name/initials in block capitals***
- ***diagnosis or main presenting symptom in***
- ***a Final Placement option***
- ***Ensure that Symphony entry is maintained***

The nature of ED work makes careful thorough documentation essential. Your notes will be read by the Emergency Department consultants who check them daily, the radiologist who reports on your x-rays, the patient's GP and, when applicable, by the doctors on the ward - *your writing must be legible!* Other clinicians must be able to work out what you did with the patient, what you said to the patient and what arrangements you made for follow-up. GPs get a computer generated letter based on the data you have entered. Medico-legal considerations mean that you must record what you say and do to every patient. The busier you are and the more tempted you are not to complete a patient's notes, the less likely you are to remember that patient when the inevitable problems arise. Don't forget that, since the FOI Act 2000 patients have a right to read their notes and frequently request copies from the Medical Records department.

If you have referred the patient to another specialty (eg gynae) YOU must still fill in the final diagnosis before the patient is discharged and YOU must do all the computer work.

Contacting GPs

It is a good idea to speak to a GP on the telephone when you decide to discharge a patient he/she has asked you to admit (if the GP vehemently opposes this plan speak to a consultant!). You will soon get to know the good GPs and it is wise to follow their suggestions, they know their patients better than we do. They can also be very helpful if you are having difficulty with a patient or if you need more information. Never ring a GP to complain or write adverse comments about GPs on the flimsy - please speak to a senior ED doctor first on every occasion.

Referring patients to other hospitals

Advice about referring specific cases can be found in the CLINICAL section but there are some general points that apply to all situations. You must obtain the NAME of any doctor who advises you about a patient and this must be recorded on our flimsy along with the advice given. Some people find this embarrassing - don't be shy, just say "could you spell your name for our records"

When you transfer a patient elsewhere make sure that you send a photocopy of the notes, results, *and an accompanying pre-formatted transfer letter*. You must ask staff to scan all the paperwork before it leaves the department.

Handing over patients to ward doctors

It is good medical practice to ensure that you have safely handed a patient over to the next doctor who will be involved in their care. Please ensure that you speak to the relevant take-in doctor about any patient who you are admitting giving them key hand-over points regarding diagnosis, progress and treatment. The SBAR method is gaining wide acceptance- please use this format.

Safer Patient Initiative

S	ituation What is going on now?	▪ State your name and Ward / Department ▪ I am calling about patient's name ▪ The reason I am calling is ..... ▪ Observations are
B	ackground What has happened?	▪ State the admission diagnosis and date of admission ▪ Relevant medical history ▪ A brief summary of treatment
A	ssessment What you found / think is going on	▪ State your assessment of the patient ▪ Have appropriate documents available, e.g. EWS, nursing and medical records, resus status, allergies etc
R	ecommendation What you want to happen	▪ I would like (state what you would like to see done) ▪ Determine timescale, e.g. NOW! ▪ Is there anything I should do? ▪ Other referrals? e.g. Acute Care Team

Do not forget to document the call

Take in doctors from the wards should not regard the hand-over contact as a request for advice about whether or not to admit the patient. The only doctors who are in a position to discharge patients in these circumstances are middle grade staff or consultants and they should be asked to examine the patient and make a record in the EMERGENCY DEPARTMENT notes. This is hospital policy **– the days of lengthy repeat assessments in EDs are officially over.**

Handing over patients to other ED doctors

This is a danger zone – it is difficult to take over a patient for someone without starting from 'scratch' and mistakes are common. The best way to avoid this situation in majors is to stop seeing new patients 15-20 mins before going off duty if this is possible. If you must leave patients for another doctor, give him/her a run down of whom you are leaving and what still needs to be done. Document in the notes the Dr who you have handed the case over to. You will have to ensure that the tracking screen is updated with your details for the handed over patient - – make sure that you log on and off Symphony or you will be held responsible for
something someone else has or hasn't done. You must record which of your colleagues is taking over the care of the patient on Symphony.

Taking enquiries and speaking to patients on the phone

The Emergency Department has a dedicated telephone helpline for ex-patients and the general public. The helpline phone is in the computer room and when it rings it should be answered as soon as possible by one of the Emergency Department medical or nursing staff. When you give medical advice over the phone you have the same "duty of care" that you have when the patient is in Emergency Department, no matter how trivial or casual the enquiry seems to be. Dealing with callers can be especially demanding - there are almost as many problems with telephone interactions as there are with incidents actually taking place within the department, so be very careful! There is a departmental protocol for the helpline, you must adhere to this.

***All telephone conversations with the public or with healthcare professionals about medical subjects must be recorded in writing* – special record sheets are provided in a file beside the helpline telephone.**

If you have spoken to a patient who has already attended, you *must* report the conversation in the patient's notes or append a copy of your completed telephone enquiry form. This includes giving results, recalling, receiving complaints etc.

If you advise patients to telephone the department for results etc, make sure that you have told somebody to expect the call before you go off duty and that you have recorded all the relevant information in the patient's notes.

Mobile phone calls from ambulance crews

All calls from ambulance crews requesting advice or on scene assistance must be directed to the middle grade doctor or consultant on call without delay. If necessary, arrange for the consultant on call to phone the crew back. Doctors in training should not advise about pre-hospital care or triage under any circumstances.

Arguments with patients and relatives

- ***"Listen to people - we aren't always right!"***
- ***"You are not obliged to treat aggressive or verbally abusive patients"***
- ***this Emergency Department has a well below average number of violent incidents***

Remember that when you are angry you are more likely to misjudge situations. Battles with relatives are notorious sources of future complaints or mistakes -be careful. *Listen to people - we aren't always right!* Keep situations calm by using phrases like "it is my job to help you" or "you're obviously very annoyed, would it help to speak to another doctor or the nurse in charge?".

Patients have the right to know your name, the name of their Emergency Department consultant and the name of the nurse responsible for their care. If a patient is dissatisfied and this cannot be resolved on the spot they have a right to make a formal complaint that can be written or telephoned to one of the Trust's complaints officers (there are leaflets about this in the waiting area). Formal complaints like this are taken very seriously and are to be avoided if at all possible. If you are locked in conflict with a patient or relatives ask a medical or senior nursing colleague to speak to them - they can usually diffuse the situation.

Some patients are violent or are mentally ill, intoxicated and so on. You must never take risks with them or endanger other staff - always ensure that such patients cannot corner anyone and that all involved in their care are aware of the danger. If you want you can carry one of the department's personal alarms when working out-of-hours. Ask the Emergency Department Sister for details.

You are not obliged to treat aggressive or verbally abusive patients and you can ask hospital security staff or the police to remove them if necessary - you do not have to treat them first. Make sure that there is *medical and nursing* documentation of such events. If a patient becomes violent, *leave as quickly as possible* and raise the alarm. In the extremely unlikely event of your being cornered by a "patient" carrying any form of weapon, wait to be rescued –other staff will raise the alarm on your behalf.

- **Experienced staff are better at handling violent/aggressive patients**
- **You must take reasonable steps to exclude a physical cause for violence/confusion – consider hypoxia, metabolic upset, CNS lesion etc.**

There are guidelines for rapid sedation of the violent psychotic patient in the CLINICAL section.

SECURITY CHECKLIST

Your safety is paramount. Be aware for potential problem patients.

Danger conditions
- Known aggressive patient or parent
- Hx of aggressive behaviour from NIAS / PSNI
- Alcohol, substance abuse
- Psychosis / personality disorder

Danger signals
- Agitation
- Confrontational
- Gesturing

Actions
1. Identify problem patients early
2. Take patient into visible open cubicle
3. Inform nurses of plan
4. Make security aware
5. Ensure own safety within cubicle
6. Chaperone
7. Try to defuse situation or use more experienced staff

If escalation of violence occurs
- Ensure own safety and that of staffs
- Call PSNI
- Document incident

Legal and Ethical Issues

All doctors are expected to have read and to adhere to the GMC's publications "Good Medical Practice" & "Maintaining Good Medical Practice" as well as their publications on transmissible diseases, research and consent. If you have lost your copies, replace them or visit the GMC website(www.gmc-uk.org). The law is also powerful and ED doctors can get into even worse trouble if they choose to ignore it. It is important to understand the law's view of the doctor-patient relationship before setting foot in an Emergency Department. An outline is given below under the heading of "consent". It is also essential to be familiar with the basics of Child Protection. In addition to the information in the clinical section and the Induction Course, you can consult the booklet "Child Protection: Medical Responsibilities" or ask a senior Emergency Department doctor.

This section covers

Chaperones
Consent
The Coroner
Court
The Police

a) Chaperones

Male doctors will be familiar with the importance of obtaining informed consent and a chaperone prior to performing intimate examinations on female patients. This principle should extended to all such examinations *irrespective of the age & gender of the patient and doctor.* While a chaperone is not necessary on every occasion, a proper explanation of the nature and purpose of the examination is. If any patient declines or exhibits any reluctance for the examination a chaperone should be offered. No examination should be carried out on a patient without consent unless it is an emergency and their capacity is impaired. Allegations of sexual misconduct have been made against Emergency Department medical staff after they have simply carried out "routine" medical procedures – you must protect yourself against such allegations.

The commonest setting for an allegation of sexual misconduct in the Emergency Department is the patient with low back pain or a suspected spinal injury. Patients do not understand why a rectal / peri-anal examination is needed in this situation – make sure consent for this procedure is fully informed.

b) The Coroner: 028 9044 6800 (also Sudden Unexpected Death in Infancy in CLINICAL SECTION)

It is NOT necessary to inform the Coroner about all deaths in the Emergency Department. He should be informed about any death due to injury and any death when neither the Emergency Department doctor nor the patient's GP can issue a death certificate. This is your responsibility – no one else can do it for you, so you must not go off duty until it is done. Out-of-hours you can leave a message on his answer-phone including your name and personal contact details. You should try to speak to the patient's GP on the phone at the earliest opportunity after any death in Emergency Department. If problematic discuss with the on-call consultant. *A pro-forma is to be filled out and left in the Emergency Department Consultant on call's office. If the patient has died in the department, a clinical summary will often be required for the pathologist- it is best to write this*

at the same time as doing the proforma and leave them together. Death certification should be done on NIECR only one copy of the death certificate should be signed.
Relatives' consent is not required for a Coroner's PM but if they indicate that they are distressed/unwilling for this please notify the consultant on call. If you think that a hospital PM is indicated in non-coroner's cases notify the consultant on call. If a patient dies in Emergency Department, record on the flimsy whether or not: (a) a Death Certificate was issued (b) you spoke to the GP (c) you spoke to the Coroner/Coroner's Office. The letter containing these details is sent to the patient's GP within 24 hours so it is essential that this information is available.

c) Coroners Letter

On the top left when identifying who you are writing to:

HM Coroner
Coroners Service for Northern Ireland
(you can add address "Mays Chambers Belfast" if you wish)

DO NOT WRITE "TO WHOM IT MAY CONCERN"

Address the Coroner as "Sir" ie "Dear Sir" or "Dear Sir or Madam" and "yours faithfully" are the correct forms for this letter
Coroner's proformas should be completed on NIECR and a copy also filed in the notes as well as forwarded to the coroner.
Statements for the Coroner (ie for an inquest) are made on a statement of witness (PSNI) form - they are statements of fact only and should normally reflect what you have written in your clinical notes. Finish with a statement of condolence ". I would like to express my sincere condolences to Mr. X's family circle.. ". This is because your statement will normally be read out in court with the family present and if you are subpoenaed you may have to read it out yourself.

d) The Police

Police officers will frequently request statements from you, eg after RTAs and alleged assaults. You can go ahead and provide these provided you report facts only (not opinion or interpretation) but seek advice from a senior doctor if unsure. If police make general requests for information or patients' details, refer them to the Consultant or SpR on call – this information is confidential and can only be released in certain situations. If police ask for a statement in reference to a Coroners investigation, they should be advised to phone Mrs Michelle Carey on extension 4661. Do not give the police a written statement directly.

Police may ask permission for the police doctor (FMO) to examine a patient or check serum alcohol. This request should only be declined if the patient is genuinely unfit – try to accommodate the police in every way possible.

e) Consent

Written consent must be obtained before any procedure such as reduction, fb removal, incision & drainage. Fingertip surgery using the Hospital's consent forms available on symphony (if in doubt re the need for written consent, ask an EM consultant)

This section on consent is taken from "12 Key points on Consent: The law in Northern Ireland"; a guideline from the Chief Medical Officer for Northern Ireland

(i) When do health and social care professionals need consent from patients/clients?

1. **Before you examine, treat or care for patients/clients who are competent you must obtain their consent.**
2. **Adults and young people aged over 16 are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: "can this patient/client understand and weight up the information needed to make this decision?" Unexpected decisions do not prove the person is incompetent, but may indicate a need for further information or explanation.**
3. **Patients/clients may be competent to make some health and social care decisions, even if they are not competent to make others.**
4. **Giving and obtaining consent is usually a process, not a one-off event. Individuals can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient/client still consents to your caring for or treating them.**
5. **Can children give consent?**

Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents should ideally be involved). In other cases, someone with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent cannot over-ride that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent from a patient/client?

6. **It is always best for the person actually treating or caring for the patient/client to seek consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.**

What information should be provided when seeking consent?

7. **Patients/clients need sufficient information before they can decide whether to give their consent; for example, information about the benefits and risks of the proposed treatment or course of action and appropriate alternatives. If an individual is not offered as much information as they reasonably need to reach an informed decision, and in a form they can understand, his/her consent may not be valid.**

Is the patient's consent voluntary?

8. **Consent must be given voluntarily; not under any form or duress or undue influence from health or social care professionals, family or friends.**

Does it matter how the patient gives consent?

9. **No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient's decision and also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.**

Refusals of treatment

10. **Competent individuals have the right to refuse treatment or care, even where it would clearly benefit them. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health (Northern Ireland) Order 1986. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.**

Adults who are not competent to give consent

11. **No-one can give consent on behalf of an adult who is not deemed competent. However, you may still treat such a patient if the treatment would be in their best interests. 'Best interests' go wider than best medical or social care interest, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these matters. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's/clients needs and preferences.**
12. **If patient/client who is now deemed not competent has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'advance refusal') and those circumstances arise, you must abide by that refusal.**

This short summary cannot cover all situations, further guidance will, therefore, be issued by the DHSSPS.

The hospital has consent forms that need to be used. It is your responsibility to know common procedures you will be doing and potential risks involved.

When using the symphony generated consent forms, you must photocopy and give a copy to the patient.

f) Court

During your time in the Emergency Department you will receive requests from the PSNI for a report regarding your care for a patient that you attended. It is your responsibility to fill in this report. You get paid for it!! If you are unsure what to do discuss it with a senior doctor. If attending court, discuss with a senior doctor. It can be arranged that you need only attend when needed. It is imperative that any summons to the Coroner's Court are discussed with a consultant.

Defensive Medicine

- ***What is it?***

Defensive medicine is commonly defined as the ordering of tests, treatments, etc, to help protect the doctor rather than to further the patient's diagnosis. Although this is not "unnecessary care", defensive medicine offers more economic and psychological benefit to the doctor than to the patient. There are two types of defensive medicine.

1) Assurance behaviour (positive defensive medicine) – providing services of no medical value with the aim of reducing adverse outcomes, or persuading the legal system that the standard of care was met, eg, ordering tests, referring patients, increased follow up, prescribing unnecessary drugs.
2) Avoidance behaviour (negative defensive medicine) – reflects doctors' attempts to distance themselves from sources of legal risk, eg, forgoing invasive procedures, removing high-risk patients from lists.

- ***Would defensive medicine lower the risk of litigation?***

No, defensive medicine is different from defensible practice, which is good practice – defensive medicine is not: it could, in fact, make your practice more risky.

Strategies to minimise defensive medical practices

- Communicate effectively with patients, explaining what you are doing and why
- Have robust systems for follow-up
- Be open about risk
- Offer an appropriate standard of care
- Only order tests based on a thorough clinical history and examination
- Discuss difficult cases with colleagues
- Keep clear and detailed documentation
- Know what it is you seek to exclude or confirm with a test to determine if it's necessary
- Identify learning needs (find good mentor)
- Undertake courses or independent study.

The Emergency Department Doctors' Rota

- ***"Leave is on a first-come-first-served basis"***
- ***"Changes must be marked clearly on the notice board copy of the rota"***
- ***Breaks are rostered into your shift, ensure that you take them.***

Doctors in training

Emergency Department F2s and STs work a full shift system involving a basic 45 hour week on average. Regular Emergency Department shifts last for nine or ten hours – ie. eight to nine hours work with 30 mins break every four hours or so. Emergency work permitting, STs will take a 30 minute break in the Emergency Department rest room (NOT outside the department) after every four hours of duty. At the end of their shift, doctors are expected to stay on duty until they have sorted out or handed over all their patients as well as helping during extra busy spells. F2s and STs' contracted weekly duties include a compulsory protected teaching & audit session from 9am to 11.30am every Thursday. Obviously the ST on leave and nights are not required to attend the teaching meeting but full attendance is mandatory for the rest (non-attendance will result in allocation of compensatory extra duties and will also result in unsatisfactory appraisal reports and references!). You MUST sign the attendance sheet every time as this is the basis for your certificate of training attendance when you leave.

F2s /STs are divided into two rotas; the A and B rota, depending on whether they are EM, F2 or GP trainees and A&B are swapped over after three months as the hours differ slightly. In practice, each ST will be paired off with an opposite number for the whole six months .The ST rota follows a repeating pattern every six weeks (there is a copy of this in Emergency Department for anyone who would like to see it). One of the consultants produces the rota, which will occasionally deviate from the pattern because of exam or interview leave etc. F2/STs can swap duties if they need a particular day off but unduly arduous, holiday relief is built in and usually there are alternate weekends off. F2s /STs are entitled to 25 days' leave each year. This means up to 13 days during six months in Emergency Department (including no more than three weekends and excluding night duty)

At least one F2s / STs must be off most of the time, usually excluding the first fortnight of August/February and Christmas week. If you don't plan this for yourselves, leave will be allocated by the consultants.. Each doctor will be unable to take certain weeks off depending on their slot in the rota, this will be explained to you when you arrive. In general, leave must start on a Monday and finish on a Sunday – it is on a first come first served basis - - you are advised to book asap.

If there is a problem with the rota, try to sort it out with your colleagues and remember to support each other – this is how all teams of doctors are supposed to work together. If this proves unsuccessful discuss it with the one of the consultants.

Middle Grade Doctors

The middle grade rota is produced by Dr Jenkins' secretary according to a rotating template. Copies are available from her. Only one of the middle grade doctors can be on leave at once. In general, leave must start on a Monday and finish on a Sunday – any deviation from this requires specific consultant permission. Leave is booked with Dr Jenkins.

Clinical Allocations

A daily allocation sheet is posted in each area. This assigns you to resus majors, paeds, minors, and tells you which of the consultants is on call. Please stick to your clinical allocation, unless it is clear that another area needs extra medical resource.

Sick Leave

You must tell your manager (Medical Directorate Office: Adrian on (028) 9442 4914 or Heather on (028) 9442 4664), if you are sick before the time you are due to go on duty or, if in exceptional circumstances this is not possible, within an hour of the time you were due to go on duty, and follow any departmental protocol in respect to reporting absence (Consultants: inform your Consultant colleagues of your sickness, Juniors: inform your supervising Consultant of your sickness).

If you work shifts, evenings or night duty you must tell your appointed contact Consultant On-Call at least four hours before the shift starts. If, in exceptional circumstances this is not possible, within an hour of the time you were due to go on duty.

If you have not already given the following information, your manager must clarify with you:

- the reason for your absence;
- how long you are likely to be off;
- what tasks will have to be covered during your absence; and
- what action has been taken by you in respect of your illness e.g. doctor's appointment

In some circumstances you may not wish to discuss your reason for absence with your manager. If this is the case, you will be referred immediately to Occupational Health, to facilitate the management of your absence.

If you are sick or unable to work for any other reason, you or your family must tell one of the Emergency Department Consultants in person as soon as possible. Failure to do this would constitute a serious breach of your professional responsibility. There can be no exceptions to this rule. The directorate office must be informed also. In line with NHS terms and conditions, the other doctors covering your part of the rota will be required to cover all sick leave unless long term sickness is involved. In practice, this will involve longer shifts for those already on duty and extra nights for those on night duty if you were due to do the nights. Standard renumeration is added for these extra shifts but they cannot be paid back – it is our duty to support the sick colleagues on our rota in the short term. Remember that sick leave rates, especially for casual sick leave, are closely monitored by all hospitals and

are almost always disclosed on references. If you are concerned speak to your Educational Supervisor. Remember that special leave such as carer's leave, compassionate leave and paternity leave may be available if you have an issue with your private life .

A word about infectious diseases...

We have high medical sickness rates due to gastroenteritis, presumably contracted from patients most of the time. Reduce your risk of this by adhering to hospital infection control procedures – hand washing works! Wear scrubs or hospital- only clothes to reduce the risk to your family. Don't eat or drink in clinical areas even on night duty. Try to stay fit during your time in EM to keep your immune system working well despite the disruption of shift work.