KF PROJECT PAPER

NUMBER 45

ACCIDENT & EMERGENCY DEPARTMENT GUIDELINES AND INFORMATION DOCUMENT

BY MID GLAMORGAN HEALTH AUTHORITY, WALES

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ACCIDENT & EMERGENCY DEPARTMENT GUIDELINES AND INFORMATION DOCUMENT

Compiled by Mid Glamorgan Health Authority, Wales

KING'S FUND CENTRE

This document was first published for use within the Mid Glamorgan Health Authority and later revised for wider use

Typeset and printed by Trident Services Ltd, London
King's Fund Publishing Office, 126 Albert Street, London NW1 7NF

Contents

Introduction

Aims of this publication

To offer guidance to staff working in an accident and emergency department (A & E department), especially for those manning the department at night when advice may be less readily accessible.

To draw out the principles of procedure, and responsibilities of communication, for those working in an A & E department. (Clinical procedures are beyond the scope of this publication.)

General points

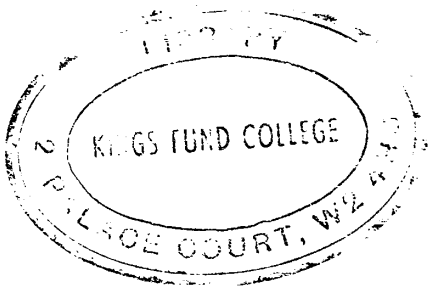
The importance of good communication between members of staff and patients and/or relatives cannot be over-emphasised. Staff in hospitals in areas with high immigrant population (including areas which have a large influx of foreign tourists) might find it useful to keep a stock of language cards and/or a list of local interpreters or members of staff who are able to converse in foreign languages. The latter could be kept with this A & E publication for easy reference.

A further point which should be emphasised is the importance of staff remaining courteous at all times of day and night when in contact with other members of staff, patients and their relatives.

Textual information

In order that this publication be used to its best advantage, spaces have been left blank in the appendices for relevant information to be inserted by local administrators before the publication is circulated.

It should be noted that the phrase 'sister-in-charge' will be used when referring to the sister or charge nurse who is in charge of the accident and emergency department.



Introduction

PART ONE

Reception, examination, registration, treatment, discharge and transfer of patients

1 Reception of the patient

1.1 Preliminary assessment of the patient's condition and allocation to treatment area

Pre-arrival information about a patient's condition (particularly in the case of a suspected emergency) may be relayed to the A & E department prior to the arrival of the patient by:
Ambulance control
Police
Fire brigade
General practitioner
Industrial medical officer
Industrial nurse
Relatives, friends

If the hospital is nominated to receive patients following a major incident, the major accident procedure must be invoked.

Telephone calls giving pre-arrival information should be taken wherever possible by clinically trained staff and not by reception staff.

It is the responsibility of the first recipient of pre-arrival information about a suspected emergency to see that such information is passed on immediately to the sister-in-charge.

If a doctor takes the call giving pre-arrival information, he should also inform the sister-in-charge.

The effective display of pre-arrival information (for example, on a blackboard) is advised, as this assists in communication, mental preparation of department staff, monitoring the arrival of patients, and notification of any deterioration or delay en route. This display is also the responsibility of the first recipient of the information.

1.2 Preliminary assessment of the patient's condition on arrival at the A & E department

Any person who presents himself at an A & E department must be seen by a doctor.

A preliminary assessment of the patient's condition prior to the arrival of the casualty doctor will be made by the nursing staff, who will ensure at this point that all information is obtained from ambulance crews, reception staff, relatives and so on.

In the case of a suspected emergency it is the responsibility of the

preliminary assessor to notify the sister-in-charge immediately.

1.3 Seriously ill/injured patients

The efficiency of all staff within the A & E department with regard to their own duties and communications with other staff members is of the utmost importance, as is the dependence on teamwork.

It is the responsibility of the sister-in-charge to ensure that the casualty doctor is called without delay.

At no time must an unconscious patient be left unattended.

All patients must be registered, but the preliminary assessment of the seriousness of a patient's condition will determine the timing of the registration procedure. Clinical procedure will always take priority over registration procedure. (Registration procedure is on page 15.)

Relatives should be informed as soon as possible. This is the responsibility of the sister-in-charge; if a particularly distressed reaction is anticipated, the police may be asked to visit relatives rather than informing them by telephone. Appendix 1 (page 44) has space for telephone numbers of your local police.

1.4 Allocation of patients to treatment areas

The flow diagram on page 11 explains the allocation of patients.

If the doctor is not yet present, the nursing staff should place patients in the area of the A & E department considered appropriate to their treatment.

1.5 Children

Although children cannot be completely shielded from the sights and sounds of an A & E department, the methods of reception and treatment may be of considerable importance to the child's subsequent physical and mental recovery. Unless more appropriate accommodation is available, steps should be taken to segregate children from the main department, possibly by designating a specific reception and treatment area.

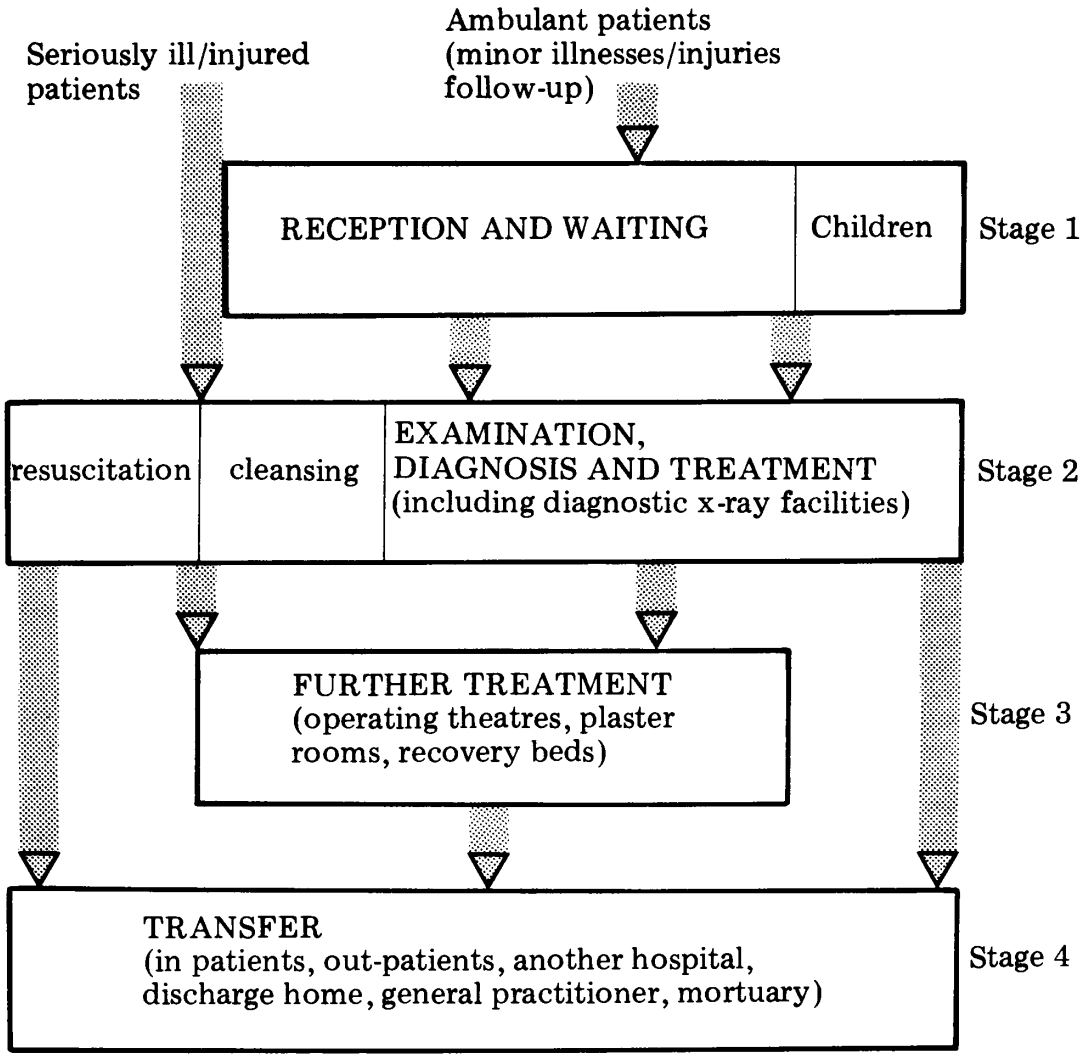
1.6 Waiting arrangements for relatives and friends

In general, relatives and friends should wait in the specified waiting area (although exceptions to this rule may be made at the discretion of the sister-in-charge).

The relatives of seriously ill/injured patients should be accommodated in an area away from the specified waiting areas, preferably in the interview

room. Beverages should be offered.

Nursing staff should ensure that non-seriously ill/injured patients and their relatives and friends are not unnecessarily distressed by undue proximity to seriously ill/injured patients.



Flow diagram of patients through an accident and emergency department

2 Examination and initial treatment of the patient

2.1 Priority for examination and treatment

The severity of the patient's illness/injuries will determine his priority for examination and treatment.

If the patient's condition does not necessitate emergency examination and treatment, the priority for examination is determined by the patient's time of arrival. (However, in the case of the very elderly, the very young, or severely distressed patients, the sister-in-charge uses her discretion.)

Decisions on the priority order for the examination and treatment of patients are ultimately the responsibility of the casualty doctor.

If necessary (either because of delay, dispute or request), patients should be informed of the procedure for determining the priority for medical attention.

2.2 Preparation of the patient for examination and treatment

The patient is prepared by the nursing staff for examination by the casualty doctor.

It is essential that the nursing staff observe the hospital procedure for property, cash and valuables:

(i) because the hospital has an obligation to safeguard a patient's property.

(ii) to counter unwarranted claims made against the hospital for the loss of a patient's property.

Clothing

(i) Minor illnesses/injuries — any clothing removed should remain with, and be kept under surveillance by, the patient. A property bag will be required.

(ii) Seriously ill/injured patients — clothing is put in a property bag, labelled, recorded in the property book and placed under the trolley.

Cash and valuables — according to individual circumstances these may be removed:

(i) from seriously ill/injured patients;

(ii) at the request of the non-seriously ill/injured.

Patients should be advised that it is in their own interests that cash and

valuables should be held for safe-keeping.

Cash and valuables may be given to any relatives who are present provided the patient is clearly in agreement. If there is any doubt or confusion the hospital should accept responsibility for them.

Cash is counted and listed with valuables in the property book by a member of the nursing staff with the patient and one witness present. Where possible, the patient should confirm by signing that the property is correctly listed. The cash and valuables are then placed in an envelope, sealed and the seal signed over by the nurse and witness.

The envelope is taken to the general office during normal working hours or deposited in the A & E department safe/night safe, out of normal hours.

Items should not be described as 'gold', 'silver' or 'platinum'; instead, the terms 'yellow metal' or 'white metal' must be used. Similarly, stones must not be described as 'diamond' or 'ruby', but as 'clear' or 'red'.

2.3 Examination and treatment — general aspects

The casualty doctor will decide if the patient requires any investigation and/or treatment.

It is a recognised principle that the casualty doctor should not hesitate to seek senior reassurance that his proposed course of action is correct.

If the A & E department is inundated with casualties and the major accident procedure is not invoked, it is the medical staff's responsibility to call in extra medical staff.

If the casualty doctor feels it is necessary to contact a member of the on-call team of a specialty other than A & E, he should telephone the senior house officer or registrar of that specialty.

The casualty doctor will personally inform the patient/parents if it is decided that no treatment is to be given, and will obtain written consent from the patient, if necessary, when treatment is to proceed (see page 28).

Doctors from outside the hospital should not be permitted to treat a patient in the A & E department as they are not members of the hospital staff. If this should arise, or be suspected, the nursing or medical staff must immediately ask the doctor for identification. However, in an emergency and where the staff had been reassured about the doctor's identity, the doctor would have a duty to treat any patient in need.

2.4 Psychological care of patients and their relatives

Patients' relatives and friends should be treated with courtesy and

consideration at all times.

Patients and their relatives should be kept informed by the casualty doctor (or his delegate) about the nature of the patient's illness/injuries and the investigations and treatment planned for their management. Regular reports, even though they may be indefinite, are better than long periods of waiting without news.

Relatives should be informed of the critical condition of a seriously ill/injured patient by the doctor and a trained nurse should normally be present to give help and support to the relatives.

Seriously ill/injured patients or their relatives may request the comfort and spiritual guidance of a minister of religion, either a hospital chaplain or a minister of their own choice. It is the responsibility of the nursing staff to contact the minister by consulting the list of ministers of all religions held either in the A & E department or at the switchboard.

3 Registration of the patient

3.1 General principles

All patients attending the A & E department must be registered on a casualty card and in the casualty register as soon as possible after the patient's arrival.

During the hours when there is no clerical cover in the reception, nurses are expected to register patients.

In view of the possibility of subsequent medico-legal enquiries, clerical and nursing staff must be meticulous in documenting all information; for example, date, time of arrival, correct spelling of names and addresses, and so on. Black ink should always be used as other colours do not photocopy well.

3.2 Seriously ill/injured patients unaccompanied by friends or relatives

As clinical procedures will take priority, registration information will have to be ascertained from these patients at a convenient stage during their examination and treatment.

3.3 Unidentified patients

If a patient is unable to communicate with staff (for example, unconscious or incoherent patients) and is not carrying any identification, the police should be asked to take over enquiries and the nursing officer should be informed.

The patient should be identified as early as possible by the nurse with an identity band stating 'patient unknown', his casualty number and also a ward number if he is to be admitted.

3.4 Non-seriously ill/injured patients

All these patients should be directed to report at the reception desk.

3.5 Road traffic accident patients

If the patient has been involved in an RTA, the RTA forms must be completed as soon as possible by interviewing the patient or relatives, and then sent to the administration office.

3.6 Monitoring and progress of patients through the A & E department

Investigations and treatments to be carried out will be written on the casualty card by the casualty doctor.

It is a nursing duty to monitor the patient's progress through the A & E department and to ensure that all investigations and treatments specified on the casualty card are carried out.

Nurses must sign their names on the casualty card against treatments given as a checking system, and to ensure that patients receive all treatments before leaving the A & E department.

If a person is missing when called for treatment, he must be called again after ten minutes. All reasonable attempts must then be made to find the patient. If a patient is still absent after the third call, a note to this effect must be entered on the casualty card. As a precaution, the police should be informed of missing persons known to be suicidal or dangerous in any way (see Appendix 1, page 44); also the patient's GP if it is thought necessary.

3.7 When the patient leaves the A & E department

The reception staff must collect the casualty cards.

The reception staff should normally complete the 'disposal' column in the casualty register (for example, patient admitted to ward) and give details of the patient's treatment.

If the patient enters the casualty theatre for suturing or other procedures, details of treatment must be recorded in the theatre register maintained by the nursing staff.

4 Further treatment, discharge and transfer of patients after examination

4.1 Patients requiring further treatment in the A & E department

The appropriate treatment is to be given by the casualty doctor (with assistance or advice from a senior colleague where necessary).

For x-ray procedures, see page 39.

The reception staff must ensure that appointments for any clinics have been made correctly.

The nurse should ensure that the patient is aware of whether he has to attend the A & E department or an alternative clinic.

Patients who do not attend follow-up appointments at the A & E department are difficult to identify, although it is essential to do so if the patient is a confused elderly person. A record should be kept of when a patient is to re-attend; in the event of non-attendance, a reminder should be issued or the patient's GP contacted.

The nurse must ensure that the patient clearly understands any medication treatment and/or precautions to be taken. If necessary, the nurse should issue the patient with the appropriate information cards. The patient should also be aware of the arrangements for returning any equipment/ appliances to the A & E department.

The nurse should establish, especially with regard to the elderly and/or incapacitated, whether the patient lives alone. If this is the case, the community nursing services, social workers and so on should be informed.

4.2 Discharge of patients from the A & E department

If a patient does not require further treatment a letter should be written to the GP indicating the treatment given.

If the patient requires further treatment from the GP:

(i) a letter should be written indicating the treatment already given and further advice to be offered to the patient, and this should normally be delivered by hand;

(ii) alternatively the GP may be telephoned and the arrangements confirmed in writing.

In either case the casualty doctor must ensure that the patient is aware that he has to consult his GP.

4.3 Patients not in need of urgent hospital attention

These patients should be reassured and referred to their own GP.

However, if they have been referred to the A & E department by a GP they will either:

(i) be given advice and referred back to their GP with a letter, or

(ii) be referred to an appropriate hospital clinic with a letter.

Reception staff must ensure that appointments are correctly made and that the relevant clinic has been informed.

The nurse should ensure that the patient is aware of the arrangements.

4.4 Patients in need of social, not medical, care

These patients should be retained in the A & E department and the social worker contacted. No patient who is incapable of looking after himself should be sent home. If necessary, he must be admitted until the social worker has dealt with his problem.

Social workers may be contacted at the district social services offices. Appendix 6 (page 52) has space for local telephone numbers.

4.5 Transportation of patients

It should always be remembered that the ambulance service is essentially an emergency service.

The decision on whether ambulance transport is necessary for a patient is always that of the doctor. If the patient is physically and mentally capable of using public transport, a taxi service, transport offered by relatives or friends, or their own transport, they should do so.

If it is thought that an ambulance is needed to convey a patient home (or back to hospital for a follow-up appointment) it is the responsibility of the nursing staff to arrange it.

In the event of a patient being discharged from the A & E department who has no money and who is not entitled to ambulance transport:

(i) during working hours, ask the general office for assistance in making contacts as below;

(ii) out of working hours, contact the patient's relatives or friends; otherwise the duty social worker (see Appendix 6, page 52) or police (see Appendix 1, page 44) may be able to assist.

4.6 Patients in need of admission

When the casualty doctor considers that a patient should be admitted, the senior house officer or registrar of the appropriate team on in-take should be contacted. In the meantime, the casualty doctor should administer necessary immediate treatment only.

The in-take team should see the patient in the A & E department as soon as possible and make frequent checks on the patient's condition to reassure the patient that he/she has not been forgotten. When the patient is transferred to the appropriate ward, the nursing officer, senior house officer or registrar of the in-take team is responsible for finding the bed.

It is the responsibility of the nursing staff to ensure that:

(i) The ward has been notified and is prepared to accept the patient.

(ii) The correct patient is taken to the ward.

(iii) The records of all drugs/treatment given, and the resuscitation record, are taken to the ward.

(iv) The patient's clothing, if it has been checked in the A & E department, is placed in a property bag and sealed and labelled with the patient's name and registration number and handed over to the receiving ward staff. Special care should be taken with dentures and spectacles as they are easily lost. If cash and valuables have not already been documented and put in the hospital safe by the A & E staff, the receiving ward staff must carry out the procedure given in paragraph 2.2.

(v) The new nurse-in-charge is aware of the situation regarding the patient's property and valuables at hand-over.

(vi) The ward staff are informed whether or not the patient's relatives have been notified.

(vii) All details are entered in the nursing records.

Relatives or friends of patients who are admitted or taken to theatre may stay in the A & E department if they wish until the eventual destination of the patient is known. They should then be escorted by a member of the nursing staff to the appropriate ward/unit. The nurse should inform a member of the staff of the ward/unit of the relatives' presence.

4.7 Patients to be transferred to another hospital

There is space in Appendix 10 (page 62) for information about regional and sub-regional specialties.

The medical team in clinical charge of the patient should arrange the transfer. Under no circumstances may a member of the nursing staff arrange the transfer of a patient to another hospital on her own initiative.

The transfer of a patient to another hospital must be clearly understood by all parties concerned and recorded in writing in the notes. The responsibility for avoiding misunderstanding rests with the doctor relinquishing charge and he will send a letter with the patient to the receiving hospital.

The casualty doctor should inform the patient's GP of the transfer in writing.

The nursing staff should:

(i) Ensure that case notes, doctor's letters, medication sheet and x-rays accompany the patient and that the appropriate reception clerks are informed.

(ii) Inform relatives of the transfer, if necessary by police message.

(iii) Ascertain whether the patient has any dependents who are unable to look after themselves, for example children or the elderly, in which case it may be advisable to contact the community nursing service about visiting the family.

(iv) Inform the receiving ward of any special treatment given or information gained and whether the patient's relatives have been told of the transfer.

(v) Obtain a witnessing signature from the receiving ward for the patient's property and valuables after checking the items.

(vi) Enter the transfer in the nursing records.

(vii) Arrange for the return of A & E department equipment by the receiving hospital.

Transport. The patient will normally be taken by ambulance, accompanied by a trained nurse and, if appropriate, a doctor. The sister-in-charge will be instructed by the doctor to arrange transport through the ambulance liaison officer. If the doctor feels police escort is required this will also be arranged by the sister-in-charge.

5 Procedures to be adopted in the event of death

5.1 Cases found to be 'dead on arrival'

The casualty doctor on duty must examine the patient to certify that death has occurred.

Death may only be verified (not certified) in the ambulance at the discretion of the casualty doctor concerned.

If death is verified in the ambulance, the body should be taken directly to the mortuary — untouched — and the doctor concerned should ensure that the coroner's office is informed.

If the patient is taken to resuscitation and later verified to be dead, procedure for death in the department (see paragraph 5.2) is adopted.

5.2 Death in the department

It is the duty of the doctor to inform the coroner about death:

(i) in circumstances which are violent, suspicious, unknown or unnatural; and

(ii) if death occurs within 24 hours of the patient being brought into the A & E department.

Arrangements for dealing with bodies suspected of being coroner's cases should be checked with the local coroner's office.

If there is any doubt as to whether a body which is a coroner's case should be touched, the police, as coroner's officers, must be consulted.

When dealing with a body which is a coroner's case:

(i) The nursing staff, in the presence of the police, may seek some form of identification of the body if necessary.

(ii) Nursing staff should make the body presentable (for example, remove drip and straighten) for identification purposes.

(iii) Property and valuables must be checked and listed according to the normal procedure.

(iv) The decision as to the disposal of the property of the deceased patient should always be made by a senior administrative officer.

(v) Property required by the police to assist them in their enquiries may be taken away by them provided it has been listed and a receipt issued.

5.3 Care of relatives and friends of deceased patients

Informing relatives of unaccompanied patients. If they are known they should be notified at once by the sister-in-charge. If they are unknown, every effort should be made to trace them. The police will assist in this and also take urgent messages.

Informing relatives accompanying the patient. The doctor should inform relatives of the death of the patient. A senior nurse should normally be present to give the relatives help and support.

The bereaved may request the comfort and spiritual guidance of a minister of religion, either a hospital chaplain or a minister of their own choice. It is the responsibility of the nursing staff to contact the minister by consulting the list of ministers of all religions held either in the A & E department or at the switchboard.

Information for the bereaved. A member of staff should be responsible for giving information to the bereaved and should be contacted without delay. See page 25.

PART TWO

Additional information, advice and guidance to A & E staff

PART TWO

Additional information

6 Battered wives

6.1 This is a widely used expression for wives who have received injuries, often serious, at the hands of their husbands.

6.2 Presentation at the hospital is used not only for observation of their injuries, but as a 'place of safety'.

6.3 The police can only be informed and become involved if the wife wishes to prefer charges against her husband for criminal assault or bodily harm. If she does not, she will be discharged once her treatment and/or observation has been completed.

6.4 The services of a social worker should be offered.

7 Bereaved relatives and friends

7.1 Notification of death

If relatives are not in the hospital, it is customary for the hospital to notify only the person named as next of kin. This person is then expected to inform all other relatives/friends. Relatives may obtain detailed advice regarding the procedure following a death from a member of staff in the general office/medical records department.

7.2 Hospital procedures

The next of kin/executor is required to attend the hospital to obtain the death certificate, complete an authorisation for the funeral directors and collect any personal effects.

Money should only be released upon production of probate of a will or, in the absence of a will, letters of administration obtained from the probate officer. However, amounts of cash up to £10.00 and personal property can be handed over to the next of kin and a receipt obtained.

7.3 Registration of death

After receiving the death certificate, the next of kin/executor should go to the registrar of births and deaths. The office hours of the registries vary and relatives should be advised to telephone the nearest registry.

The registrar will ask for the following details:

(i) full name of the deceased;
(ii) last known address;
(iii) date of birth;
(iv) occupation (before retiring);
(v) whether the decesased was receiving a pension.

The relative should also give the deceased's medical card to the registrar.

After registration of death, the registrar will issue a certificate enabling the funeral to take place which relatives should give to the funeral director.

The registrar can also issue a certificate for a social security death grant, as well as extra copies of the death certificate if required.

7.4 Cremation

If the deceased had expressed a wish to be cremated, or if the next of kin wish cremation to take place, the doctor should complete a cremation form.

7.5 The doctor must inform relatives when it is necessary to report a death to the coroner's office.

7.6 Post-mortem examinations

A post-mortem examination may be required to establish the cause of death. If a post-mortem is not ordered by the coroner but the doctor wishes to hold one, the decision to agree to a post-mortem rests with the next of kin alone.

7.7 The will

Matters concerning the estate of the deceased are best referred to a solicitor.

7.8 The hospital chaplain

The sister-in-charge should offer the services of the hospital chaplain.

7.9 Social workers

The sister-in-charge should also offer the services of the hospital social workers.

8 Complaints from patients or other persons on behalf of patients

8.1 Verbal complaints of a simple nature may be dealt with on the spot by the member of staff approached.

8.2 If this is not possible, the sister-in-charge should be informed. If the complaint concerns any sphere of duty for which the sister-in-charge is solely responsible, she should commence investigations and report the outcome verbally to the patient (or person complaining on behalf of the patient). If the complainant is not satisfied, or if the complaint lies outside the sister's sphere of responsibility, she should refer the matter to the nursing officer.

8.3 The nursing officer will, if necessary, advise the complainant to refer the complaint, preferably in writing, to the appropriate administrator.

8.4 Even if the complaint is successfully dealt with by the A & E department staff they should inform the nursing officer that the complaint was made and that the complainant was satisfied with the outcome.

8.5 Staff members should address complaints made by them on behalf of, or in the interests of a patient, to their immediate superior. If the complaint concerns the staff member's immediate superior, the staff member should make the complaint to the chief officer of his profession. A copy of serious complaints should be sent to the consultant in charge of the department, whether or not there was a direct medical involvement.

8.6 Complaints involving alleged loss of property should be brought to the attention of the nursing officer, the administrator and the security manager.

8.7 If a complaints book is kept in the department all complaints, even if given and answered verbally, should be entered in it.

9 Consent to treatment

Informed consent to treatment must be obtained from the patient. If informed consent is not obtained and treatment given, an action for damages could result. Where there is time, senior medical or nursing officers should be consulted before proceeding with any treatment where consent is an issue.

9.1 A patient is considered to have given his consent to medical examination, medical treatment (including injections) and minor surgery (for example, suturing) by his arrival at the A & E department and his subsequent cooperation.

9.2 If any operation, internal examination under anaesthetic, or exploratory procedure is undertaken, the patient's consent must first be obtained in writing on the appropriate form.

A doctor should tell the patient in non-technical language about the nature and purpose of the proposed procedure or operation, and about any special risks of which the patient should be aware.

The patient must sign the form of consent at the time of explanation. The doctor should immediately sign to the effect that he has explained the nature of the treatment to the patient and should also ensure that the entries are legible.

9.3 Consent forms

Every care must be made to ensure that the patient signs the correct consent form. There are nine forms in the HMR5 (Consent) series currently in issue.

Responsibility for ensuring that the correct form is presented to the patient rests with the medical staff.

9.4 Conditional signature or refusal to sign

If a patient refuses to sign a consent form, or declares any reservations or makes conditions (even verbal) when signing, the doctor must decide, in the exercise of his own professional conscience, whether or not he will treat the patient or operate under the limiting conditions propounded by the patient.

9.5 Patients unable to give consent

If a person is incapable of giving consent to treatment as a result of accident or sudden illness and it is important that treatment proceeds

without delay, it should be carried out on behalf of the patient with the consent of the nearest available relative.

Relatives may refuse to give consent to treatment (for example, on religious grounds) in the belief that they are expressing the patient's views. However, where a blood transfusion or other procedure is necessary in order to attempt to safe life or to prevent serious disablement of suffering, it should, as a rule, be carried out despite objection by a relative, even if the objector claims to be expressing what he believes would be the patient's wishes.

The doctor will also approve treatments in an emergency if relatives are not quickly traceable.

9.6 Children under sixteen years of age

A child under sixteen is normally in the custody and control of a parent or legal guardian from whom consent to treatment should be obtained.

If emergency treatment is necessary and a parent or legal guardian cannot be traced in time, the consent of the child may be sufficient if, in the opinion of the doctor, the child understands the nature and effect of his consent. However, the consent of the parent/guardian should only be dispensed with in these very exceptional circumstances.

If treatment is desirable but not necessary, a parent or legal guardian's consent is needed and their objections cannot be ignored.

It is unwise to go against a specific refusal on the part of a child who, in the opinion of the doctor, understands the nature and effect of his consent.

In some circumstances it is advisable to seek the consent of both parents. In the case of a disagreement between the step-parent and the natural parent of a child, the step-parent has no parental rights; nonetheless, the step-parent's opinion might merit consideration on medical grounds.

It is desirable to obtain consent from a person who is responsible for a child but is neither parent nor legal guardian, although it does not have the authority of law.

Refusal of parental consent

If it is believed that the withholding of treatment would endanger the child's chances of survival, the doctor, after full discussion with the parents, should exercise his clinical judgment. The doctor should also obtain a written supporting opinion from a colleague that the patient's life is in danger if an operation or transfusion is withheld, and an acknowledgment (preferably in writing) from the parent or guardian that,

despite the explanation of the danger, consent has been refused. In these circumstances, the doctor would run little risk in a court of law if he acts with due professional competence and according to his own professional conscience in undertaking the procedure.

10 Detention of patients

No one may be detained in hospital without lawful authority. It is not sufficient justification to say that the detention is in the patient's interest.

10.1 Exceptions to this rule are:

A person suffering from a mental disorder who is liable to be detained under the Mental Health Act 1983.

A person who is in the custody of the police, although the hospital has no legal responsibility for the safe custody of the person.

A person unable otherwise to receive proper care and attention and who is a danger to himself or others and is being detained under a Justices Order.

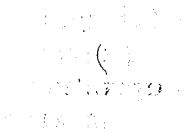
10.2 Self discharge of a patient not liable to detention

In all cases where a patient insists on discharging himself, other than those stated above, he must be allowed to go.

The patient must be warned by a doctor or trained nurse that his action is against medical advice and that the hospital and its staff take no responsibility for any consequences.

The patient must sign the appropriate hospital form to the effect that he is discharging himself against medical advice. If he refuses to sign he cannot be detained, but the doctor/senior nurse and a witness should sign the appropriate hospital form to this effect.

If a patient refuses to continue with treatment once it has begun, the doctor/senior nurse and patient must record the refusal in the patient's records and indicate the nature of the treatment refused.



11 Donation of organs and removal of tissue

The Human Tissue Act 1961 specifies the purposes for which human tissue can be removed during a post-mortem examination. It also specifies the provisions it is necessary to follow.

11.1 The authorisation of the person lawfully in possession of the body must be obtained in each case of organ or tissue removal.

When death occurs in hospital the person lawfully in possession of the body would normally be the health authority responsible for the hospital, at least until relatives or executors ask for the body to be handed to them.

Except in a case where the deceased made an express wish to donate tissue, the removal of tissue may be authorised *only* if, after having made reasonable enquiries, the person lawfully in possession of the body has no reason to believe that the deceased had expressed objection or that a surviving spouse or other relative objects.

Specific consent is not required by the Act, yet it is desirable that a surviving spouse or other relative should be invited to sign a standard post-mortem declaration form. This is a precaution against the possibility of unauthorised removal and also affords evidence that the requirements of the Act (as to the enquiries to be made) have been complied with. It is accepted, however, that there will be occasions when only oral enquiry is possible.

11.2 Before the removal of cadaveric organs for transplantation can be effected, a diagnosis of brain death must be made by two independent doctors, one a consultant and the other a consultant or senior registrar. Neither doctor should be a member of the transplant team. Diagnosis should not normally be considered until at least six hours after the onset of coma, or, if cardiac arrest was the cause of the coma, until 24 hours after the circulation has been restored. A checklist should be completed in all cases (see Appendix 4, page 50).

11.3 Removal can only be effected by a fully registered doctor who has satisfied himself by personal examination that life is extinct. Others may act under that doctor's personal supervision and direction.

11.4 It is improper and of doubtful legality for parts of the body so removed to be sold for gain by any person, although it would be reasonable for them to make charges for transport and so on.

11.5 The provisions of the Act apply when a post-mortem examination is ordered by a coroner (as they apply to any other post-mortem examination) except that the removal of organs also requires the consent or approval of the coroner.

11.6 *Appendix 2* (page 45) contains a summary of the provisions of the Human Tissues Act.

Appendix 3 (page 49) contains specific instructions regarding Kidney transplantation.

Appendix 4 (page 50) is a checklist of criteria for diagnosis of brain death. This checklist should be completed and should form a permanent part of the hospital case record in all cases involving organ transplant.

12 Hospital 'hoppers'

12.1 These people may be:

drug addicts, for example pethidine addicts;

psychosomatics;

hypochondriacs;

anyone seeking overnight accommodation.

12.2 They normally complain of severe abdominal colic, chest pain, renal colic as well as other illnesses.

12.3 If the doctor or nurse has reason to suspect that a patient is a 'hopper', they should refer to the appropriate file or circular which gives names and information about known 'hoppers'. 'Hoppers' often use aliases but these are normally close to their real name. The appropriate community physician should be informed so that full details can be circulated to other hospitals.

12.4 If staff are certain that they are dealing with a 'hopper', the doctor may instruct that placebo injections (sterile water for example) be given, following which the 'hopper' may discharge himself.

13 Non-accidental injury to children

The A & E department staff may be the first to receive a child suspected of being the victim of maltreatment by its parents or other adults.

13.1 *Definition* of non-accidental injury (NAI). NAI has occurred when a child under sixteen years of age has suffered maltreatment, or has been severely neglected by his parent, guardian or other person.

13.2 *Classification.* Cases of NAI may be:

Clear cut. A case is clear cut when

(i) a parent, guardian or other person makes a statement about an injury to a child that he or another person has inflicted;

(ii) clear medical evidence shows that ill-treatment has taken place.

In these cases arrangements must be made for the child to be medically examined by a paediatrician. In most cases it will be appropriate to admit the child to hospital while enquiries are made.

Suspected. A case is suspected when there are indications that an injury or other condition (for example, 'unexplained failure to thrive') is caused by the ill-treatment or neglect of a parent, guardian or other person *but* where no clear or medical evidence exists, or where no statement is made, or where the degree or type of injury is at variance with the explanation given.

In such cases it is important to identify the degree of risk to the child and to take any necessary steps to protect the child. This is done by the collection of all available relevant information and the initiation, where appropriate, of these procedures.

13.3 Information regarding NAI is confidential.

13.4 The Medical Defence Union has stated that:
it would support any doctor who disclosed information about a battered child to a party concerned for its protection; that legally it would be held unnecessary for a doctor to ask the consent of the parent to inform an agency such as the NSPCC or a local authority that a child was being ill-treated; that a doctor could be held to have failed in his duty if, having suspected or diagnosed child abuse, he failed to take steps to prevent further injury or the death of the child.

13.5 Diagnosis

Firm diagnosis is rarely possible at the earliest stage, although various methods of identifying NAI cases may be employed.

Clinical conditions

Attention should be alerted when a child is seen with:

(i) a fracture of any bone, particularly *shearing injuries* of long bones;

(ii) *subdural haematoma;*

(iii) soft tissue swelling or skin bruising;

(iv) peculiar burns, bruises or scratches;

(v) *repeated* injuries;

(vi) unexplained failure to thrive, especially if associated with rapid gain in hospital;

(vii) where the degree or type of injury is at variance with the history given;

(viii) where there has been a delay in seeking medical advice;

(ix) sudden death.

Checking with the central register of children at risk (see Appendix 5, page 51).

Daily checks by the paediatric health visitor on the records of all A & E department attendances by children.

Hospital casualty doctors seeking the opinion of the paediatrician at the earliest opportunity, if necessary by referring the child to another hospital.

13.6 Colour marking of the casualty card to indicate a suspected or known case of NAI should be discreet so as to avoid queries being raised unnecessarily by the child's parent/guardian.

13.7 Staff should familiarise themselves with the specific procedure used by the casualty records staff in their own A & E department.

13.8 Appendix 5 (page 51) contains guidance on the use of the central register of children at risk. *Appendix 6* (page 52) contains space for addresses and telephone numbers of local social services departments.

14 Infectious diseases and food poisoning

14.1 If a case of infectious disease is suspected by the nursing staff who are receiving patients:

The patient should be isolated in a cubicle as early as possible.

The casualty doctor should be called to examine the patient at once.

The appropriate hospital routine for isolation and/or barrier nursing of all suspected cases until proved negative should be followed.

14.2 Notification of cases of listed notifiable infectious diseases and food poisoning is a statutory obligation and is the responsibility of the doctor who assumes clinical responsibility for the patient. He must notify:

The appropriate community physician (by telephone).

The control of infection officer (by telephone).

The local authority, by completing the standard notification form within twenty-four hours of diagnosis.

14.3 *Appendix 7* (page 53) contains a list of all notifiable infectious diseases.

Appendix 10 (page 62) has space for the telephone number of the High Security Infectious Disease Unit.

15 Pathology services

15.1 All pathology specimens must be sent to the appropriate laboratory in an appropriate container with the standard request form. All information asked for on the form is of importance.

15.2 Procedures for urgent laboratory tests may vary.

15.3 If an urgent laboratory test is required out of hours, the appropriate person on the emergency rota should be contacted. (Junior doctors are reminded that only essential requests for laboratory services should be made outside normal working hours.)

16 Pharmacy services

16.1 Patients attending the A & E department who require outpatient medication will receive a hospital prescription which will be dispensed as follows:

At the hospital pharmacy during office hours.

From the emergency stockroom/drug cupboard outside office hours in an emergency, or in cases where it is essential that a patient receives prompt treatment.

From the duty high street pharmacy.

16.2 It is advisable for the home telephone numbers of pharmacy staff to be known at the hospital switchboard in order that they may be contacted in exceptional circumstances.

17 Poison and drug cases

The initial treatment is to be given in the A & E department and in the hospital pharmacy.

17.1 Antidotes are held in the A & E department and in the hospital pharmacy.

17.2 The poisons information centre

Appendix 10 (page 62) has space for location and telephone number. The centre will know the toxicity of the main ingredients and provide an outline of suggested emergency treatment. The contact will be a clerk on duty but medical consultation by telephone is available if required.

17.3 The A & E department should have:

Reference books/cards from chemical manufacturers regarding emergencies involving chemical transporter vehicles.

Pictorial charts to aid the identification of berries and so on which children may have eaten.

17.4 Drug dependant patients should be referred to the relevant addiction treatment centre for further assessment and treatment (page 62).

17.5 Because a patient who has taken a controlled drug may be on the register compiled by the Home Office, the name of the patient should be notified immediately to the drugs branch of the Home Office - not to the police.

18 Police enquiries in the A & E department

18.1 Police and the patient The police acknowledge that a patient's clinical treatment takes priority over any business they wish to conduct.

The police may only approach a patient for a statement with the consent of the doctor immediately responsible for the patient's care.

If the police wish to photograph a patient, the patient or next of kin must give permission.

18.2 If the patient is suspected by the hospital staff of committing a serious crime:

Disclosure to the police about the patient and his affairs may be sufficiently justifiable in the public interest.

The advice of the senior doctor or nursing officer should always be sought.

However, it is important that the patient's trust in the nursing staff should not be forfeited by too ready a disclosure of minor matters.

18.3 Prisoners, with their accompanying police offers, should be kept separate from other patients as far as is practicable.

18.4 Nursing staff must not give written statements to anyone, including the police, without the permission and in the presence of a nursing officer. If desired, a representative of their professional association or union may be present.

18.5 Road traffic accidents (RTA)

A police officer must ask permission of the casualty doctor before making a breathalyser test.

The same procedure applies if a police doctor or police officer wishes to take a blood or urine specimen. The police do not object to the presence of a hospital nurse/doctor during these proceedings and they should attend if sufficient staff are available.

In the event of an RTA, a doctor may be required to give information to the police under compulsion of law and regardless of the possibilities of breaching professional confidence.

18.6 If it is suspected that the patient is a victim of foul play, the police must be notified by the doctor. In the case of a suspected murder the body must not be touched. The consultant in charge of the case should be notified of all action proposed.

19 Press enquiries

19.1 Staff in the A & E department must *not* give information about patients to the press.

19.2 Any enquiry from the press should be referred to the nursing officer or a senior administrator who will contact the appropriate doctor for information about the patient's condition.

19.3 If the patient's relatives are not aware of his condition no information at all is to be given.

19.4 Requests from the press to interview a patient must also be referred to the nursing officer or senior administrator. The doctor's permission will be sought first and then the patient's permission.

19.5 If these requiremements have been met, the patient's name and a summary of his condition may be given to the press. Under no circumstances is clinical information to be divulged.

20 Radiology services

X-rays should be taken for medical, not legal reasons.

20.1 No request for an x-ray should be made unless the patient has been assessed and the request form completed and signed by a doctor.

20.2 Efforts should be made to reduce the number of calls on the duty radiographer after normal working hours.

20.3 Junior doctors requesting urgent x-ray examination, in or out of normal working hours, should try to ensure that it is essential, if necessary by discussing the matter with the relevant consultant.

20.4 It is desirable that a consultant radiologist or senior member of the medical staff should check all x-ray reports each morning to ensure that misinterpreted x-rays are brought back for review.

21 Rape cases

21.1 The gynaecological registrar or consultant should be informed as soon as possible. This does not preclude the casualty officer from carrying out any procedures necessary to deal with other injuries demanding immediate attention.

21.2 The gynaecological department might wish the patient to be examined by a police doctor who has had specific training in the taking of specimens because an examination carried out by someone else might prejudice future legal proceedings.

21.3 It may be helpful to tell the patient about the Rape Crisis Centre in London which helps women to cope with the aftermath of rape, such as pregnancy tests and applying for compensation. The service is free and women are not pressed to go to the police, although they are helped if they wish to do so.

21.4 The Centre runs a confidential 24 hour phone service (01 340 6145) and can refer people in the provinces to local help.

22 Suicide attempts

22.1 When attempted suicide is suspected, the patient must be admitted and a psychiatrist consulted before the patient is discharged.

22.2 Where there are no indications for compulsory admissions under the Mental Health Act of 1983, a patient is entitled to discharge himself against medical advice.

23 Trespassers on hospital property

23.1 Anyone who is on hospital premises without the express or implied consent of the hospital authority is a trespasser.

23.2 Anyone who has reason to be in the hospital (for example, a patient's relative), but who refuses to leave at the request of a person acting on behalf of the hospital authority, is also considered to be a trespasser.

23.3 Only reasonable force should be used to remove a trespasser.

Where reasonable force fails, the police should be contacted.

It is desirable to have a female trespasser removed by female members of the staff (provided there is no undue risk to themselves).

23.4 Details of all incidents, together with the names of witnesses, should be recorded in accordance with individual hospital procedure.

24 Violent patients

24.1 General guidance

It is important that *all* staff coming into contact with patients be thoroughly familiar with the problem of violent patients and the procedure for dealing with them.

The action to be taken to deal with threatened violence or an act of violence is a matter of judgment in the light of the particular circumstances and of the principles of good practice outlines in Appendix 8 (page 54).

Physical restraint may sometimes be unavoidable in the interests of the staff, the other patients, and the violent patient himself.

In violent incidents the initiative for taking or directing action should rest with the most appropriately experienced senior professional present; however, every employee must accept responsibility to call for assistance and to take action.

24.2 Means of summoning assistance

It is essential that readily accessible and effective means of quickly summoning assistance should be provided. The number of staff on duty in the A & E department should, at all times, be enough to meet this need.

The type of patient liable to be involved in violent outbursts in A & E departments may be accompanied by police officers whose help and expertise should be called on. If the police are not present, they may be contacted for assistance.

24.3 Training

Staff should receive appropriate training. Training in the course of ordinary duties should supplement lectures or discussions. When incidents of violence have occurred there should be full discussion of the causes and of the correctness of the action taken. Since no statement of principles can deal comprehensively with every eventuality the discussion will increase staff awareness of appropriate procedures before, during and after the incidents, and form a valuable method of reviewing deficiencies in the training given.

Staff may expect their actions to be judged sympathetically by their supervisors and the health authority. This does not mean that an authority will condone or try to defend actions it judges to be wrong or inappropriate, but it does mean that blame will not be attached to a member of staff who has acted in good faith and in accordance with the training he has received.

24.4 The value of professional organisations, trade unions and staff associations in providing assistance and advice to staff involved in violent incidents should be stressed.

24.5 Patients suffering from the effects of alcohol, drugs or poisons

The handling of patients in a state of temporary intoxication in a way that avoids violence is a skill which staff should be given the opportunity to acquire.

24.6 Patients suspected of possessing offensive weapons

They should be asked to hand over weapons for safe custody. If this is refused, or possession is denied, the police must be contacted (Appendix 1 page 44 has space for telephone numbers). It may be necessary to search the patient and his belongings in order to remove the weapon in the interests of other people.

24.7 Reporting and review of incidents

Each hospital should have an adequate system for recording and reporting any incident involving violence by a patient, whether or not it has occasioned damage or injury to any person. This is to protect those involved and to provide material for an analysis of the incident.

All reports of incidents that occasion injury to persons or serious damage to property should be copied to the health authority.

Every hospital should also have an adequate system for deciding whether it is appropriate to inform the patients' relatives about their violence. This can only be decided in the light of the particular circumstances, but if doubt exists it should be done. Staff will be safeguarded and the relatives helped in making decisions about the patient's future.

24.8 Injuries to staff

Staff may have rights to compensation under the Industrial Injuries Scheme and the Criminal Injuries Compensation Scheme and should be aware of the procedure for making claims.

Industrial injury benefit is claimed by completing the appropriate medical certificate from the medical practitioner consulted, including the portions relevant to industrial injury. Claims should then be sent to the local social security office (if they are not sent within six days of the start of the incapacity some benefit may be lost).

In order to qualify under the Criminal Injury Compensation Scheme, staff must report the circumstances to the appropriate health authority without delay. If this is done, the Criminal Injuries Compensation Board will waive

their usual requirement of immediate notification to the police. The Board requires that the report to the health authority should enable it to make a proper decision about the need for police involvement.

24.9 *Appendix 8* (page 54) contains the Principles of Good Medical and Nursing Practice in the Management of Acts of Violence in Hospital prepared by the Royal College of Psychiatrists and the Royal College of Nursing.

Appendix 1

Local police constabulary

Headquarters

Principal stations

Appendix 2

Summary of Human Tissue Act 1961

Section 1

Provides that under specified conditions a part of the body of a deceased person may lawfully be removed and used for therapeutic purposes or for medical education and research.

Subsection (1) provides for the body of a deceased person or any specified part of it to be used for therapeutic purposes or for purposes of medical education or research when the person in his lifetime has so requested in writing or orally in the presence of two witnesses during his last illness. If the deceased has made such a request, the subsection empowers (but does not require) the person lawfully in possession of the body to authorise the removal of any part of the specified part for use as the deceased requested, unless he has reason to believe that the request was subsequently withdrawn.

Subsection (2) provides that where the deceased has not requested in accordance with Subsection (1) that his body or a part of it may be so used, the person lawfully in possession of the body may still authorise removal of any part of it for similar purposes if, having made such reasonable enquiry as may be practicable, he has no reason to believe that the deceased in his lifetime had expressed any objection to this, or that the surviving spouse or any surviving relative objects.

Any relative of a deceased person may object to the use of the body for the purposes specified and this will override a lack of objection on the part of other relatives (but not the deceased person's own wishes if he has expressed them in the way indicated in Subsection (1)).

Subsection (3) makes lawful, subject to Subsections (4) and (5), the removal and use of any part of a body provided the necessary authority has been given by the person lawfully in possession of it.

Subsection (4) requires that only a fully registered medical practitioner is to remove parts of a body under the terms of the Act, and he must satisfy himself by personal examination that life is extinct. By the definition in the Medical Act, 1956, a fully registered medical practitioner includes a person who has passed his final examinations and who, while doing his year's service in hospital to secure full registration, is required to do the removal in the course of his hospital work. It also includes a person temporarily registered under Section 25 of the Medical Act, 1956, if the removal forms part of the duties of his employment in respect of which he has secured temporary registration under that section.

Subsection (5) provides that authority may not be given without the consent

of the coroner to remove parts of a body if there is reason to believe that a coroner may require an inquest or post-mortem examination to be held. There is thus an obligation in such a case on the person who can authorise removal to obtain the coroner's consent and also on the doctor, who with that authority proposes to remove parts, to obtain it or see that it is obtained. This is a safeguard to ensure that the coroner is in no way fettered or defeated in any enquiries into the death which he may think necessary. The consents in Subsections (1) and (2) will also be necessary in addition to the coroner's consent.

Subsection (6) precludes undertakers from giving authority for removal of parts of bodies.

Subsection (7) Where an in-patient dies in a hospital, nursing home or other institution and the governing body is lawfully in possession of the body, this subsection empowers the governing body to designate an individual to give authority (subject to the necessary consents) for the removal of parts of bodies.

Subsection (8) makes it clear that the Act does not make unlawful any dealing with, or with any part of, a body which is lawful apart from the Act.

Section 2

Makes clear that post-mortem examinations (other than those directed or required to be made by a competent legal authority) if carried out for the purpose of establishing or confirming the causes of death or of investigating the existence or nature of abnormal conditions will not contravene the provisions of the Anatomy Act, 1832 (an Act which gave power to grant licenses to practice anatomy and laid down the conditions under which bodies could be used for anatomical examination). Doubts have been expressed as to whether that Act does or does not apply to the examinations described in this section and Section 2 removes any uncertainty there may be about the legality of such examinations carried out in accordance with it.

Subsection (1) specifies the types of post-mortem examinations to which the Anatomy Act, 1832, is not to be construed as applying.

Subsection (2) lays down the conditions under which such post-mortem examinations must be carried out. They must be carried out by, or in accordance with the instructions of, a fully registered medical practitioner. The words 'in accordance with' cover the circumstances where a student or attendant acting under the doctor's instructions may assist and do part of the work.

The subsection further provides that except where the post-mortem examination is ordered or requested by the coroner or any other competent legal authority, the person lawfully in possession of the body must give his

authority and that the requirements of Section 1 (2), (5), (6) and (7) will apply with the necessary modifications. That is:

(a) reasonable enquiry must be made to ensure that the deceased had not expressed objection in his lifetime and that the surviving spouse or any surviving relative does not object;

(b) the coroner's consent must be obtained if there is reason to believe that he may require an inquest or post-mortem examination;

(c) an undertaker may not give authority;

(d) the governing body of a hospital, nursing home or other institution may designate an officer to authorise on their behalf the examination, subject to the other requirements in regard to consent.

Section 3

Provides that bodies used for anatomical examination may, as an alternative to burial, be cremated in accordance with the Cremation Acts, 1902 and 1952, and that in such a case the certificate of cremation is sent to the inspector of anatomy.

POST-MORTEM CONSENT .....HOSPITAL

.....WARD

I do not object to a post-mortem examination being carried out on the body of

Name .....

Address .....

.....

.....

and I am not aware that he/she would have objected or that another surviving relative objects. I understand that this examination is carried out:

(a) to verify the cause of death and for further study and to remove limited amounts of tissue for these purposes;

(b) to remove limited amounts of tissue for the treatment of other patients.

Signed .....

Relationship to deceased .....

Witnessed by .....

Date .....

Notes on the completion of this form

1. The signature of a relative of the deceased should be witnessed by the member of staff administering the form.

2. A relative of the deceased should not be invited to sign this form if the hospital is itself aware of objections on the part of other relatives.

3. Should a relative be content that a post-mortem examination of the body be made but object to the use of tissues for treatment, appropriate deletions may be made to the form.

HMR 5A VIII(V) 77 Date of death .....

A post-mortem consent form

Appendix 3

Kidney transplantation

Any patient admitted to the A & E department who is dying in spite of every attempt at recuscitation should be considered a candidate for donating kidneys or renal transplantation.

NB Most of these patients will be seen initially by junior medical staff who may not be aware of the procedure.

Enquiries should be made as to whether the patient suffered from hypertension, kidney disease or recurrent urinary infection. These would preclude the use of the kidneys for transplant; infectious or disseminated malignancy also needs to be excluded, and severe atherosclerosis.

The renal transplant team should be contacted as soon as possible.

The renal transplant team will arrive equipped with all the necessary materials for removing the kidneys and they will also interview the relatives if desired.

While awaiting the arrival of the renal transplant team, care should be taken to see that the patient does not become anoxic or grossly hypotensive. Antibiotics may be required. Hypothermia occurring after death has been diagnosed need not be corrected because it may favour organ survival.

Appendix 4

CHECKLIST OF CRITERIA FOR DIAGNOSIS OF BRAIN DEATH

Diagnosis to be made by two independent doctors one a consultant and the other a consultant or senior registrar. Diagnosis should not normally be considered until at least 6 hours after the onset of coma or, if cardiac arrest was the cause of the coma, until 24 hours after the circulation has been restored.

Name . . . . . Unit No . . . . . .

PRE-CONDITIONS

Are you satisfied that the patient suffers from a condition that has led to irremediable brain damage? Specify the condition:	Time of onset of unresponsive coma:
Dr A	. . . . .
Dr B	. . . . .

Are you satisfied that potentially reversible causes for the patient's condition have been adequately excluded, in particular:

	Dr A	Dr B
Depressant drugs		
Neuromuscular blocking (relaxant) drugs		
Hypothermia		
Metabolic or endocrine disturbances		

TESTS FOR ABSENCE OF BRAIN-STEM FUNCTION

	Dr A		Dr B	
	1st testing	2nd testing	1st testing	2nd testing
Do the pupils react to light?				
Are there corneal reflexes?				
Is there eye movement on caloric testing?				
Are there motor responses in the cranial nerve distribution, in response to stimulation of face, limbs or trunk?				
Is there a gag reflex? (If the test is practicable)				
Is there a cough reflex?				
Have the recommendations concerning testing for apnoea been followed?*				
Were any respiratory movements seen?				

	Dr A	Dr B
Date and time of first testing	. . . . .	
Date and time of second testing	. . . . .	

(As stated in paragraph 30 of the Code of Practice the two doctors may carry out the tests separately or together.)

Dr A Signature . . . . . Dr B Signature . . . . . .

Status . . . . . Status . . . . . .

*Diagnosis of Brain Death. Brit Med J 1976, ii, 1187-8.
See note (b) on page 35 of the Code of Practice

Appendix 5

The central register of children at risk

The Register exists to provide a central point of reference for those doctors needing information on children known or suspected of having suffered non-accidental injury. It is intended as a guide to diagnosis and contains only information necessary to identify a child and his family, including brothers and sisters.

Names are entered on the register only by agreement of a case conference; similarly, names are removed by a case conference decision.

Access to the register (operated on a call-back system) is limited to the following people:

Social services department

Social workers, senior social workers, district social services officers

Medical services

Registered doctors

Nursing services

Health visitors, nursing officers, ward sisters (paediatrics and A & E)

Police

All police officers

NSPCC

Social workers

Probation service

Probation officers

Enquiries to the register should be telephoned to the local social services department

Normal office hours:

Out of hours:

Appendix 6

Social services department

Appendix 7

Notifiable infectious diseases

A doctor who suspects that a patient is suffering from one of the following infectious diseases is required to notify the fact to the medical officer for environmental health who has been appointed by the district local authority.

Acute meningitis
Anthrax
Cholera
Diphtheria
Dysentery
Encephalitis
Food poisoning
Infective jaundice
Lassa fever
Leptospirosis
Leprosy
Malaria
Marburg disease
Measles
Ophthalmia neonatorum
Plague
Poliomyelitis
Rabies
Relapsing fever
Scarlet fever
Smallpox
Tetanus
Tuberculosis
Typhoid and paratyphoid fevers
Typhus
Viral haemorrhagic fevers (for example, 'Ebola fever')
Whooping cough
Yellow fever

Appendix 8

Principles of good medical and nursing practice in the management of acts of violence in hospital

Prepared by the Royal College of Psychiatrists and the Royal College of Nursing

Prevention first objective

While the violent outburst cannot always be avoided, prevention should be the first objective of professional effort: in this connection professional staff should bear in mind the importance of the following points.

The instruction of junior doctors by consultant medical staff about the significance of violence as a manifestation of mental disorder and its relationship to environmental factors that may foster its expression.

Medical staff must continue to recognise and accept their obligation to cooperate with nursing staff to prevent violence in the ward. This cooperation includes an obligation for the consultant or his deputy to make himself available at the earliest opportunity following a violent incident so that a mutual exchange of information can take place with nursing staff with regard to appropriate treatment and management.

It is important to avoid overloading the nursing staff on any ward. When considering the admission to hospital of a potentially disturbed patient, the doctor responsible for the patient should make full enquiries, including discussions with nursing staff, as to the most appropriate place for his care.

The prevention of violence requires a knowledge and understanding by nurses of individual patients and a quiet surveillance of those factors which may precede a period of disturbed behaviour. Such signs as increasing emotional instability, changes in normal habits, anxiety, depression or bizarre behaviour ought to alert nurses to consider the causes of the change and to bring these factors to the notice of medical staff as soon as possible so that appropriate action may be taken. It must be recognised, however, that this may not always be possible, especially in the case of newly admitted patients and in accident and emergency departments, and that unforeseen incidents may occur particularly in relation to alcoholism, drug dependence and epilepsy.

Clinical notes should be kept on the ward where the patient is resident or in a readily accessible place and should contain the fullest possible information to facilitate treatment of the patient.

Attitude of staff to patients

A proper professional attitude by staff to patients is important in both the prevention and management of violent incidents. This should be guided by the following principles.

The patient must be accepted as he is, as a person in need, regardless of behaviour, class, creed or colour. Whether he is likeable, irritating or socially deviant should make no difference to the professional attitude of staff although the degree of personal control which may at times be needed to achieve this should not be underestimated.

It is important for the nurse to be someone on whom the patient can rely. This requires effort by the nurse to control his or her own emotions. Over-reaction to the emotions of a patient will interfere with the nurse's essential objectivity.

The nurse must at all times maintain a correct professional relationship with the patient. In the course of their professional work it is inevitable that nurses will obtain a great deal of personal information, often of an intimate nature, about patients. Such information must be treated as strictly confidential and discussed only within the therapeutic team and then only in the context of the patient's care and treatment.

Nurses must accept that violent episodes may occur with some patients and should remain sensitive to those signs that may indicate incipient violence, using nursing skills to prevent its eruption; should violence nevertheless arise, they should be prepared to deal with it effectively. Some groups of patients merit special mention.

(i) The first group are some brain-damaged, severely mentally handicapped patients who are subject to unpredictable violent outbursts. They may have to be physically controlled until these outbursts have subsided, for their own safety and the safety of others. Great care must be exercised since such control may on occasions be misinterpreted as ill-treatment by uninformed visitors to the ward.

(ii) The second group consists of psychopathic patients. These may be of borderline normal intelligence and cared for in units in mental handicap hospitals or they may be of high intelligence and in other units. Violence more commonly arises between such patients than between the patients and staff of the unit who become involved secondarily in controlling these violent outburst. It is in units such as these that nursing staff are most vulnerable to sometimes unfounded allegations of ill-treatment which may be difficult to refute in the absence of independent witnesses. Similar considerations will apply to some mentally ill patients perhaps particularly to those subject to hallucination and/or delusion and to those in conditions of acute mania.

When violence has been controlled there should be no change in staff's professional attitude to the patient.

Dealing with a violent episode

Action should be guided by the following principles.

Staff faced with a potentially violent situation should try to be calm, confident and objective.

Talking and listening should be the first line of approach. Physical intervention should be avoided if possible but may be necessary if it seems likely that someone will be hurt.

Damage to property does not necessarily justify immediate physical restraint. If, however, the patient is breaking windows or causing other damage likely to result in injury, staff must try to divert his attention or to stop him.

The degree of force should be the minimum required to control the violence and it should be applied in a manner that attempts to reduce rather than provoke a further aggressive reaction. The number of staff involved should be the minimum necessary to restrain the patient while minimising injury to all parties.

(In law, the general position is that a patient may be restrained, or a nurse or other person may protect himself, only with such degree of force as is necessary and reasonable in the circumstances. The more serious the danger the greater the degree of force which may be used to avoid such danger and vice versa. Active intervention need not be confined to the person who is threatened by the patient; another person who is not threatened may come to the assistance of the person who is threatened. If it is evident that a violent patient is about to strike somebody he may be restrained before the blow has actually been struck.)

Any member of staff finding himself or herself alone faced with a potentially violent situation should not attempt physical intervention before adequate assistance has been obtained unless it is absolutely essential that he or she does so.

Medical assistance can be very important in dealing effectively with certain kinds of incident. A call for such assistance must be treated therefore as a matter of urgency by the duty doctor or any other medical staff. The need for assistance to be rendered quickly when requested is quite distinct from the need for a review by the patient's own consultant or his deputy at the earliest opportunity after an incident.

Staff have a responsibility to go to the assistance of any victim of the violent patient's attack, no matter who that victim might be.

If a member of the staff is attacked he must obviously use the most appropriate means available to defend himself and this of course will be a matter for personal judgement. If it is possible for the member of staff to remove himself from the immediate vicinity of his attacker he should do so, but only if it can be accomplished without putting at risk the other patients in his charge.

As a general principle, clothing rather than limbs should be held to effect restraint and if limbs have to be grasped they should be held near a major joint in order to reduce the danger of fracture or dislocation. Every effort must be made to safeguard the patient's vulnerable areas, for example, the neck, throat, chest or abdomen.

A patient who has to be restrained should, when possible, not be gripped by the head, throat or fingers. A bear hug from behind to pinion the arms to the side is valuable and it is better to grip the legs together just above the knees and around the calves rather than separately. If the patient is brought to the ground, he can be very quickly subdued if sufficient members of staff lie with their weight across his legs and trunk and thus immobilise him until further action is decided upon. In exceptional circumstances, as for example, when a patient is biting, the hair may have to be firmly held.

If an intra-muscular injection is given great care must be taken to avoid accidents in its administration.

Should a patient need to be isolated, it should only be for the minimum period necessary until the patient is under control and with the consent of the doctor immediately concerned with the patient's care.

It is recognised that the action suggested for dealing with violent episodes does not cover all eventualities and there will be a need for staff to use considerable initiative in this area. In some instances of extreme violence the degree of force needed becomes a matter of concern for the nurse and it is only possible to reiterate that the degree of force should be the minimum required to control the violence and that it should be applied in a manner calculated to calm rather than to provoke further aggression. It is also recognised that even when all reasonable precautions are taken, physical injury may be caused to the participants in a violent episode.

Reporting violent episodes

There are distinct though closely inter-connected reasons why it is essential to have an adequate recording and reporting system. Among these is the need to assist the good professional care of the patient and to provide material for an analysis of the incident which may be helpful to his future treatment and may suggest preventive action against future outbursts. Other reasons are the need for good management, and the need to ensure that any subsequent complaints can be adequately dealt with.

The reporting arrangements in any hospital should therefore be designed to meet both management and professional requirements. The following are relevant professional considerations.

It is recognised that there is difficulty in deciding what degree of severity of violence warrants detailed reporting of the incident. It is considered that any of the following indications should lead to a full written report:

(i) Any incident involving physical violence and injury by a patient to himself, other patients, to members of staff or to any other person, or any allegation of such an incident.

(ii) Any incident which necessitates the use of physical restraint of a patient by members of staff.

(iii) Any incident in which isolation for more than a short period forms part of the management of the disturbed patient.

(iv) Any incident causing significant damage to hospital property or to the property of patients or staff.

Such a full report must be brought to the attention of every member of the therapeutic team as well as to that of the appropriate authority.

The responsibility to initiate the reporting procedure should be with the person having the duties of nursing officer of the unit at the time of the incident, unless the patient is in the charge of some other person outside the ward at that time. In cases of doubt a more senior nurse must be consulted.

The principal contents of an appropriate questionnaire are listed below to indicate the kind of information which should be recorded:

(i) When the incident occurred.

(ii) Where the incident occurred.

(iii) A brief factual account of the incident which should include the general activity occurring at the time of the incident and the names of those immediately involved.

(iv) The action taken:
a. immediately;
b. following the incident, which should include the time that senior officers were informed and when they took action.

(v) The names of all additional persons bearing professional responsibility for the management and investigation of the incident where these were not listed at (iii).

(vi) The principal content of the incident including the main direction of aggression.

(vii) Observations on the mental state of the violent person.

(viii) Any injury or damage that has occurred.

(ix) Any additional comments on the incident.

Even when an incident does not fall into any of the categories listed above (and a full report is not required) an appropriate brief note of the incident should nevertheless be made by the senior individual handling the incident. This note should be brought to the attention of all staff who may have a direct professional concern and it should be filled in on the patient's clinical notes. It may be necessary for the physician attending and/or the nurse in charge of the patient's ward to make additional comments.

Copies of reports on episodes of violence should be retained in the hospital.

Appendix 9

Coroner's cases

The following are the circumstances in which the doctor should report the death of a patient to the coroner.

Abortions not due to natural causes, and maternal deaths if in any way suspicious.

Accidents or injuries which are not limited to events within a year, or any particular time, and are considered as in any way contributing to the cause of death.

Alcoholism, whether acute or chronic.

From the administration of any anaesthetic whether general, local, lumbar, or in the form of pre-medication, including all deaths occurring within 24 hours of the administration of an anaesthetic.

In childbirth where death of mother or child is due to childbirth injury caused by external means.

Want of attention at birth.

Death caused by the taking of drugs, either therapeutic or where addiction caused or contributed to death.

Industrial diseases — any pathological condition arising out of the nature of the deceased's employment, and all diseases and poisons prescribed under the Factories Act or under the National Insurance (Industrial Injuries) Act.

Cases where relatives make allegations about treatment and so on, or suggest that the death may not be natural.

Self-neglect or self-inflicted injuries.

Want or exposure, privation, starvation.

Operations — operative shock including all deaths occurring within 24 hours of the act of operation.

Poisoning — from any cause; for example, occupational, accidental, suicidal or homicidal, and also food.

Septicaemia and so on, after injuries or stings.

Sudden or unexpected deaths.

(i) Where the real, as opposed to the terminal, cause of death is not known or where the deceased has not been attended to during his last illness.

(ii) Which are violent or unnatural, including those where there is any suspicion in the mind of the doctor or relative that anything unnatural (for example accident in the past) may have contributed to the death.

(iii) Where any baby is not seen alive by the certifying doctor.

Appendix 10

Specialty services

Drug Addiction Centre

Renal Unit

Neuro-Surgical Unit

Burns Unit

High Security Infectious Diseases Unit

Poisons Information Centre

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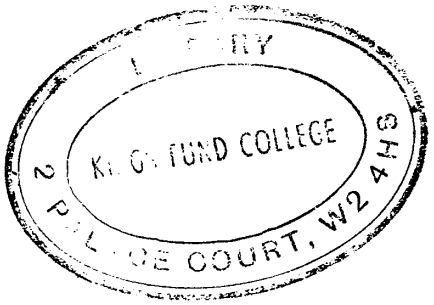

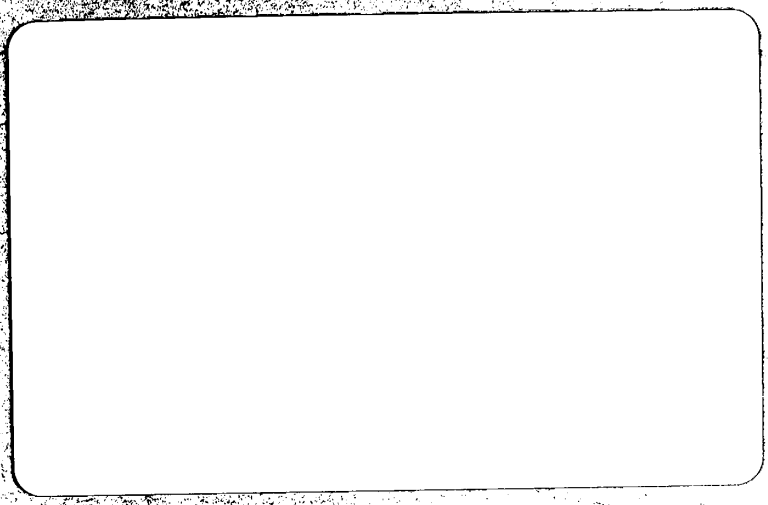

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