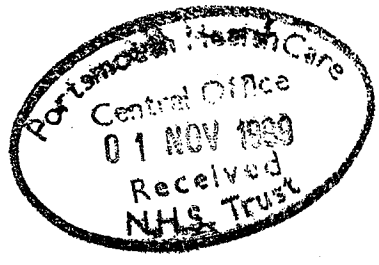
Portsmouth HealthCare NHS Trust
MEMORANDUM

From
Barbara Robinson

Ref
BFR/svn



To
Max Millett

cc

27 October 1999

Max

Learning Points from the Wilson Complaint

Thank you for your memo and the copy of Dr Turner's letter.

1a) Microfilming/Fluid Chart

It was an unfortunate error that these particular notes were microfilmed so quickly. Notes are not usually filmed until at least one year after the patient has died or 3 years after discharge.

The company have assured us that everything is filmed except blank sheets and address labels.

2b) Nursing Care Plans

This has been picked up as part of the Clinical Governance Action Plan for Community Hospitals. It was also part of an action plan from a workshop on May 20 '99 for Clinical Managers and Clinical Practice Development facilitators. This action plan was evaluated on 20 October '99 and showed that work with Nursing Care Plans has taken place across all areas in the community Hospitals.

I will raise it at NAC to ensure it is being picked up Trust wide.

3d) Good Practice in writing up medication.

It is an agreed protocol that Jane Barton, Clinical Assistant, writes up diamorphine for a syringe driver with doses ranging between 20 and 200 mgs a day. The nurses are trained to gradually increase the dose until the optimum level has been reached for the patient's pain relief. If the prescription is not written up in this way the patient may have to wait in pain while a doctor is called out who may not even know the patient.

Ian may wish to raise this at the Medicine and Prescribing Committee

I hope this covers all the points

Code A