#TEXTDrJaneBarton
Doctor05.03.02
#CODE
CA since 1988 - res 2002 - 12 years. Before 1998 - was very gentle job. Really can ward round an understanding.
12K - 1.5k patients of hers.

1998 - cc no longer ?? - most had Bctel L4 - no understanding rels - pressure acute end greater and greater.

Feb 2000
Involved working party use of continuing care beds couldn't achieve 80% bed occupancy

Protocols shown not wrote them pat and ill should have been in acute unit.

Letter JB - dangerous - pat put at risk - greater interests?? Understanding workload at.
Letter from D Jarratt

Guidelines at the end of 2000. Sent as to practice. 1st set of criteria for Daedalus.

Res 28/7/02 - following that (letter) review paper - prop increased med input - trust hoped for her input as PCG Chair.

Diaries - average 5 pat a week into 42 beds. Where are they going - lot a re dying.
Pat transferred, ?? appropriate - rels not always given but prep and knowledge of nurse guidelines - eg GP carer. Not can cover 24 hrs/bleeps etc.

1998 - lots of time at strategic meeting at St Mary's.

Always tried to see rels as soon as possible and explain not a high intensity unit 90% understood.

GW lovely job of dignity and looking after. Doing what best v seriously ill patients.

Effect on elderly on moving them. Must have prolonged effect on length of life - would be sig on these groups of people.

HCT not total no. of complaints - do have - 1997 op O per year. 1998 - complaints started happening and other complaints.
Reflects pat/rel expectations.

Reply to D Jarretts letter 1st time - raised concern. 1998-2001 got on with job - thought supp my nursing staff in retrospect - stupid.

No can cover on Dryad when Jane Tandy on maternity leave - she covered it - foolish.

Strategic level - PCG level - did that stop you formally ?? look can and do job for time with renumeration giving because - knew no slack in system.

What drove her - loved it when started it. Knew and trusted them - all thought doing a good job.

Knew Althea asked and staff etc - and knew said no, so not place to.

TL how re jig system to stop system repeating - in more acutely and complex care unit - must staff unit shift - say pub not a H hospital - understand diff level of medical care. Way employer looks after and treats you.

1st unit of police - letter from HCT nothing to do with them, get in touch with MDU. No one prep to stand up.

Staff being bullied by media and small number of relatives

Sultan beds - £1 a day to look after - always a privelidge to have those beds. Pressures on time and risk.
Trust will loose resource if not look after GP properly.

When see a complaint looming (Mrs McK) - no one in there to go to for help (except Consultant) Dr L on study leave. Is a duty geriatrician on call - what could he have done. No management support from hospital - for nursing staff and her. No difference in level of support.

Did say to people - not hear to put down on paper - would suggest write to people with complaint earlier.

Management style of trust is to write and apologise.

Management support v. Dr Lord and Barton - v poor - Dr Lord was in for some time.

Would like to have seen managers deal with relatives - earlier and like to have felt management?? On their (incl Nurses) side.

On call cover - leave till am and Dr B will deal with it. Felt isolated towards the end.

MDT basis and working together GP's have a more independent Practice. How manage conflict of natural sides of GP spirit in a MDT in a trust??

Was that tension recognised.
No tension on Dryad therefore had no call cover - once a month (if many) or a locum (not prep to see relatives) Daedalus - Enormous respect Dr C meeting ward rounds with her learnt an awful lot.
One stage PT and OT and multi-disciplinary meeting before saw patients.

MDT - meetings did one ward round with her once a week.

Calling on call - consistant?
How did that work? Any new rota after a comp in 1998. think would have rung Althea at first instance. Relied on her quite heavily.

When on hols - one of partners asked duty can to come down - which he did - she didn't do that - didn't need to.

D & D like GP beds in Sultan with Althea in background.

Dep audits - descend on us occasionally. Eg. continence products. Clinical on teaching services Org. Althea and refresher once a year. Nothing flawed out out re change in case

unit.

Evolving stresses mirrored by the CA's

How patient assessed
Nursing assessment - then Dr B see them and relative if around.
Need time to see existing records - examine and write up med and with luck talk to a relative

"Generally continent" - etc not always right - generally worse than what expecting. Difficult to make Bartel assessment. Need a couple of days to cambillation?? Purposes. Then what to say to relatives when granny not going to rehabilitate.

Then have to start to talk to family about what want when any news then a couple of days. Should have ?? back to acute - not an option.

Couldn't do IV fluids ?? used sb - ?? fluids sparingly.

If such case arrives late in week - anticipatory prescribing to tie over 3/4 days.

JB requires total trust in nursing staff - never abused opiates. Never inappropriate weekend??

Could ring at home - more practical to have anticipatory prescribing. Needed complete faith. Looked like a wide range - look at clinical prescribing - not abused - made by trusted nursing staff.

Nurse staffing strength and calibre - was paramount and reliable at that time (circa 1998)

Pall care input/opinion - easy to get hold of Countess Mountbatten Dr Beewee? - would give advice could ask opinion on Sultan ward - superb service.

Went to refresher courses and RC guidelines etc.

Is a Countess Mountbatten booklet too green?

No ?? drugs out with reglatory practice.

GP's Lloyd George folder - one line to describe and lots of space - still worked on Lloyd Georges principles - 40 pats in 45 mins - notes always brief.

Poss to have consulted with palliative care specialists and not write in notes. Her notes apparently brief therefore time constraints.
Always tried to have nurse with her for discuss with rels for them to make note.

Help pharmacy staff Jean Dalton - once a week. Wed lunchtime - was able to discuss with her and her boss at St Mary's available for help and would query her prescribing if necessary.

When started had pharmacist on site - went off to St Mary's

GP environment - decisions of GP enjoy high level attention, not be v much challenge.
Observation - never felt personally challenged. Only one nurse left her had diff over use

of opiates. (Duleancy) Had to rely and trust them. If was disagreement - would do what felt appropriate.

Drugs were on chart for them (nurses) to make decision.

1998 started writing policies before that relied on actual judgement.

Confirmation of death - had to gave a certificate to say confirmed death. If wrote sentence in notes - mautician on duty not home to call.

Dr B issued certificate - into medical records gave permission for them to use certificate.

Such an entry would be routine.

Training and education.

Refresher courses and Countess Mountbatten - Randis? is too. Would org PGE herself.

Can f?? Rawas received talk on care of dying - org themselves

Updating on countsheet drug use - no absorbed as went on. Bereavement breaking bad news - no as went along.

Mrs McK - when made a complaint - became aware as soon as came in had note book. Did best to keep in picture - though not committed to paper. Input into trust response - no, not invited to.

Trust provide supp trying this - no - review in 2000 - what happened?

Trust did appr 2 weeks ago - suspend - then Ha came around to suspend - and voluntarily agree to not prescribe opiates and cant look after any pats at GWM or on opiates.

ie no support.

HA docs cause for concern - did that - how describe it. Following first hearing at GMC. DPH said told by region to investigate - 7 weeks investigation performance in GP - no idea where get info.

Policy on prescribing etc. - any involvement - may be would have through PCCT role.

Trust in nurses - mean in place, help you know nurses competent - was quality of reports got on aim ward round.

Lack of support from trust - what about before and involved in arrangements clin governance.

No

Appraisal systems - no involvement.

How east to tap into policies and management - clin governance to help 'us'.

Who was aware of what time coming in - common knowledge ?? there kinds of ??. Not

difficult until 1997.

Agreement as trust employee - private study time etc - no.

Job description 1988 - not updated.

After clinical governance - aware support for nurses - yes aware.

Nurse with problems in palliative care - had come from a nursing home - difficulty with opiates all together. Her personal call.

GP's in hospital - appraisal a gap - process may have highlighted a problem earlier - though not governance resource.

Chairman regrets about whole issue and distress of relatives - not all intent to inform anyone.

TL in term of prevention - resistance in system to make it possible to look after these patients.

Takes v robust Management system. Doesn't think PCT will help together with SMA takes a step back.