Patient Safety Matters

PROMOTING A CULTURE OF SAFETY AND QUALITY AMONGST JUNIOR DOCTORS ISSUE 1 March 2016

You and Patient Safety

William Lea

Welcome to the first issue of 'Patient Safety Matters'. This monthly newsletter is aimed at keeping doctors in our trust up to date with national and local safety issues. We will also let you know how and when to get involved.

What is patient safety?

The World Health Organisation gives the following definition:

Patient safety is a fundamental principle of health care. Every point in the process of care-giving contains a certain degree of inherent unsafety.

Adverse events may result from problems in practice, products, procedures or systems. Patient safety improvements demand a complex system-wide effort, involving a wide range of actions in performance improvement, environmental safety and risk management, including infection control, safe use of medicines, equipment safety, safe clinical practice and safe environment of care.

Every member of staff in our trust should be aware and involved in patient safety. Bruce Keogh had the following to say about junior doctors and patient safety:

"Junior doctors……have penetrating insight into how things really work – where the frustrations and inefficiencies lie, where the safety threats lurk and how quality of clinical care can be improved"

We are all busy and it can be difficult to keep up-to-date; through this newsletter we plan to provide you with what you need to know in an interesting and engaging format.

Sign up to Safety campaign
https://www.england.nhs.uk/signuptosafety/
Subscribe to the mailing list for regular updates.

63% of doctors have not used the Prevention of Contrast Nephropathy Guidelines, available on the intranet.

"Day of admission appears to have little impact on mortality in the acute hospitals"

Trust Mortality Review report Oct 2015

Top 10 Causes of Death

1 Pneumonia
2 Cancer
3 Heart Failure
4 GI
5 Sepsis
6 Stroke
7 Multi Organ Failure
8 Intracranial haemorrhage
9 Renal failure/AKI
10 Other respiratory

Trust Mortality Review report Oct 2015

Royal College of Physicians

"Handover, particularly of temporary 'on-call' responsibility, has been identified as a point at which errors are likely to occur."

Search 'RCP handover' for more information

PHARMACY UPDATE

Penicillin allergy – We are continuing to see patients with documented penicillin allergy being prescribed penicillin containing antibiotics. Please be aware and check with the patient and on the drug chart/CPD before prescribing any medication, but especially penicillins.

Individual incidents to learn from: A patient was recently prescribed Dalteparin 12,500units and Dalteparin 5000units together for 4 days. The Dalteparin (12,500 units) was only prescribed on the chart and no green chart was filled in. The patient's platelet count was 19.

Helen Holdsworth, Deputy Chief Pharmacist (Helen.holdsworth@york.nhs.uk)

DRUG SAFETY ALERTS

from the MHRA/NHS ENGLAND

• **Nicorandil can cause serious skin, mucosal, and eye ulceration, including gastrointestinal ulcers which may progress to perforation, haemorrhage, fistula, or abscess**

• Use nicorandil for treatment of stable angina only in patients whose angina is inadequately controlled by first line anti-anginal therapies, or who have a contraindication or intolerance to first line anti-anginal therapies such as beta-blockers or calcium antagonists.

• Stop nicorandil treatment if ulceration occurs—consider the need for alternative treatment or specialist advice if angina symptoms worsen.

Spironolactone and renin-angiotensin system drugs: risk of fatal hyperkalaemia

Monitoring of blood electrolytes is essential in patients co-prescribed a potassium-sparing diuretic and an angiotensin converting enzyme inhibitor (ACEi) or an angiotensin receptor blocker (ARB) for heart failure.

Reminder for healthcare professionals:

- Concomitant use of spironolactone with ACEi or ARB is not routinely recommended because of the risks of severe hyperkalaemia, particularly in patients with marked renal impairment.
- Use the lowest effective doses of spironolactone and ACEi or ARB if co-administration is considered essential.
- Regularly monitor serum potassium levels and renal function.
- Interrupt or discontinue treatment in the event of hyperkalaemia.

Risk of severe harm/death if Desmopressin is omitted in patients with cranial diabetes inspidus

This was issued following 56 reports to NHS England, 4 of which resulted in severe dehydration or death due to omission of desmopressin for cranial diabetes insipidus.

Within the trust we've had one reported incident where a patient missed 3 days of desmopressin which led to urinary incontinence, hypernatraemia (155) and delayed discharge.

If you have a patient on Desmopressin for cranial diabetes insipidus please highlight it as a critical drug and ensure nursing staff are aware of the importance of not omitting this medication.

Visit https://www.gov.uk/drug-safety-update for more information and updates

Yellow Card

The Yellow Card Scheme is vital in helping the Medicines and Healthcare products Regulatory Agency (MHRA) monitor the safety of all healthcare products in the UK to ensure they are acceptably safe for patients and users.

Visit **yellowcard.mhra.gov.uk** for more information

QUALITY IMPROVEMENT

Congratulations to Karen Lau (FY2), Stefin Babu Joseph (FY2) and Rashed Hossain (REG) who have had their Nasogastric Tube project accepted by the International Forum on Quality and Safety conference. They undertook this project in association with the Junior Doctor Safety Improvement Group.

The conference will be a fantastic learning experience with key patient safety experts including Charles Vincent and Don Berwick giving presentations.

We are keen to support you if you have project ideas. Get involved and you could be presenting at a local, national or international conference!

Improvement Academy

The Improvement Academy is funded by the Yorkshire and Humber Academic Health Science Network (AHSN). There are 15 national AHSNs which were created in May 2013 following a Lord Darzi report in 2008 which recognised the need for commitment to continuous improvement in the quality of care provided for patients in the NHS. The AHSNs purpose is to create and harness a strong, purposeful partnership between patients, health services, industry, and academia to achieve a significant improvement in the health of the population. They will support knowledge exchange networks to build alliances across internal and external networks and actively share best practice. All NHS organisations in the Yorkshire and Humber are members of the AHSN and therefore have access to the support, training and resources provided by the Improvement Academy.

- **Visit www.improvementacademy.org for more information**
- **There are free online courses for quality improvement**
- **The academy hosts free courses and seminars – check out the website!**

Not sure where to start or how to carry out an improvement project?

Complete the Improvement Academy's free online 'Bronze Improvement Training' package.

Upload your certificate to your portfolio.

Visit www.improvement-academy.co.uk

Recent Project: Prevention of Contrast Nephropathy Guidelines

A guideline for the prevention of contrast nephropathy is available on the trust intranet (Staff Room).

63% haven't used the guideline before.

Of those who used the guideline :

38% found it easy to follow and 18% found it easy to locate.

85% of responders would like a summary of the guideline to be available on intranet.

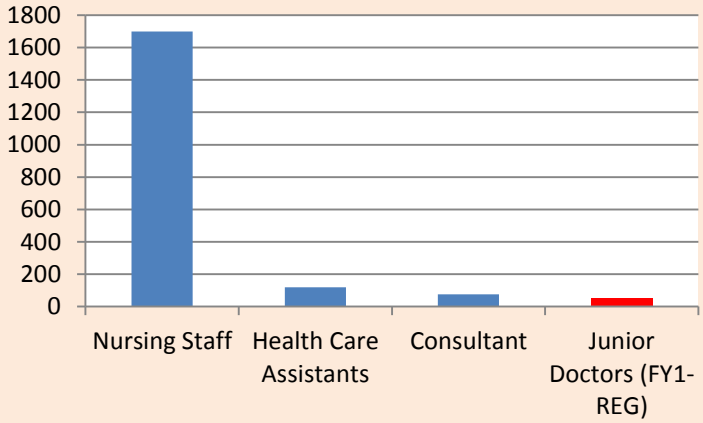
Shahd Ahmed (FY2) and **Tawassal** Riaz (FY2), at Scarborough Hospital, are working with the renal team to formulate an improvement strategy.

REPORTING

Incident reporting is a vital tool for collecting information about unintended or unexpected events which could have or did lead to harm for one or more patients.[1] It goes without saying that simply collecting this information will not improve patient safety or reduce incidents but can provide fuel for change.

Although junior doctors may be aware of and reflect on patient safety issues national and international research has shown that they do not often formally report.[2] Graph 1 shows incident reporting among junior doctors at York Teaching Hospital Foundation Trust (York and Scarborough Hospital) over a three month period. Reporting among a selection of other healthcare professionals has been included for comparison. **We are currently working on strategies to improve reporting among junior doctors and remove barriers. We will be providing some feedback on trends through this newsletter. Please get in touch with ideas! (PatientSafetyMatters@york.nhs.uk)**

Graph 1 - Incident Reports Completed Over 3 Months (York and Scarborough)



1. The National Patient Safety Agency (2004) Seven steps to patient safety: An overview guide for NHS staff. NPSA, London. 2 Hooper, Kocman, Carr, Tarrant (2015) Junior doctors' views on reporting concerns about patient safety: a qualitative study. Postgraduate Medical Journal 2015;91:251-256

William Lea, Jo Nelson-Smith, Helen Chiplin

GROUP REPRESENTATION

Attending a trust working group can be a **daunting proposition**. We are working to **empower** and **support** juniors to attend and **contribute** to meetings. Junior doctors and groups will benefit! The following groups are looking for junior representation:

- **DNACPR**
- **EPMA (Electronic Prescribing)**
- **HIPCG (Infection Prevention)**
- **MSG (Medication Safety Group)**
- **MERG (Medicine errors review group)**
- **Sepsis**
- **Deteriorating Patient Group**

Contact us for more information or if you want to get involved.

EDITORIAL TEAM

William Lea, Diane Palmer (Patient Safety), Helen Holdsworth (Pharmacy), Donald Richardson (Quality Improvement), Liz Jackson (Patient Safety), Elaine Vinter (Media & Communications)

Email PatientSafetyMatters@york.nhs.uk if you have any comments or would like to contribute.