

Patient Safety Matters

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PROMOTING A CULTURE OF SAFETY AND QUALITY AMONGST JUNIOR DOCTORS

ISSUE 12 – February 2017

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

Recording the DNACPR conversation in the medical notes is good practice as recommended by the General Medical Council (GMC)¹. A mental capacity assessment will also need to be completed, if a patient lacks capacity.

To improve the recording of the DNACPR conversation in the medical notes the Trust is introducing a **DNACPR sticker** to be used in conjunction with the DNACPR form.

A number of nurses and doctors have highlighted they were unable to find DNACPR forms, “what happens if my heart stops” leaflets, envelopes, stickers or mental capacity assessment forms readily on the wards.

Each ward has been provided with a **clear plastic folder** with all these items included. If any of these items run out the ward clerk should return the folder to the resuscitation equipment store room (York) or resuscitation cupboard (Scarborough) and ask if stocks can be replenished.

When a patient is discharged **the original DNACPR form goes home with them in the DNACPR envelope provided**. There have been a number of incidents where we have found two or three original DNACPR forms in the notes alongside the copy. The patient should be told to carry the DNACPR form with them at all times. The

DNACPR form is a cross care setting form and should travel with the patient and is valid in all care settings within the Yorkshire and Humber locality.

Tracey ruling² - All patients with capacity should be involved in the discussion and informed of the DNACPR decision (unless this will cause the patient harm). It is good practice to involve the family in these discussions.

Winspear ruling³ - In patients who lack mental capacity to make their own decisions their NOK should be involved in discussion if a DNACPR decision is to be made. This applies even if a decision is required to be made in the middle of the night.

For more information please complete the e-learning for DNACPR on the learning hub.

Anne Garry, Consultant in Palliative Medicine, anne.c.garry@york.nhs.uk

References:

¹ http://www.gmc-uk.org/static/documents/content/Treatment_and_care_towards_the_end_of_life_-_English_1015.pdf

² <https://www.judiciary.gov.uk/wp-content/uploads/2014/06/tracey-approved.pdf>

³ [http://www.mentalhealthlaw.co.uk/Winspear_v_City_Hospitals_Sunderland_NHSFT_\(2015\)_EWHC_3250_\(QB\),_\(2015\)_MHLO_104](http://www.mentalhealthlaw.co.uk/Winspear_v_City_Hospitals_Sunderland_NHSFT_(2015)_EWHC_3250_(QB),_(2015)_MHLO_104)

SPOT DIAGNOSIS



Answers on the last page.
Send us your pictures!

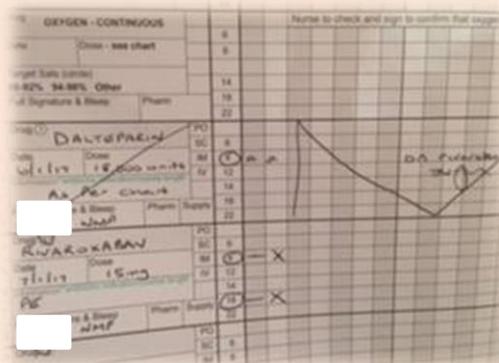
Pharmacy

Switching between Anti-Coagulants

When switching between anticoagulants please remember to ensure that you wait the recommended time between doses and that the periods of therapeutic effects are not overlapping.

For example when switching between dalteparin and rivaroxaban, stop dalteparin, write up rivaroxaban but cross out the first two doses to ensure that the first dose of rivaroxaban is not given until after 22 to 24 hours after the last dose of dalteparin.

The recommendations on switching between anticoagulants are:



LMWH to DOAC:	Wait 22 - 24 hours after last dose of LMWH before DOAC is started
ONCE daily DOAC to LMWH:	Wait 24 hours after last dose of DOAC before LMWH is started
TWICE daily DOAC to LMWH:	Wait 12 hours after last dose of DOAC before LMWH is started
Warfarin to apixaban (AF):	Stop warfarin, wait until INR is under 2.0 before apixaban is started
Warfarin to rivaroxaban (VTE):	Stop warfarin, wait until INR is 2.5 or under before rivaroxaban is started
If switching from a DOAC to warfarin, contact your ward pharmacist, the Anticoagulant Clinic (772 6785) or Medicines Information (772 5960) for further advice.	

Further information on anticoagulation in the Trust can be found on Staff room, 'Clinical Information', 'Anticoagulation and VTE'.

Jayne Knights, Anticoagulant Clinic Pharmacist, Jayne.Knights@York.NHS.UK

Broad spectrum antibiotics

In an effort to reduce the amount of broad spectrum antibiotics we use in the Trust, some changes are being made to the advice on the Adult Antibiotic Treatment Posters:



- The second line option for treatment of intra-abdominal sepsis will change from pip-taz to tigecycline
- Oral doxycycline will be introduced as an option for mild hospital acquired pneumonia (HAP) for those patients who do not require IV piperacillin-tazobactam and are low risk of Pseudomonas infection
- Pneumonia in patients coming in from nursing or residential homes will now be treated as community acquired pneumonia (CAP) and not HAP, in line with NICE guidance (2014)
- HAP is now defined as a pneumonia that develops 48 hours or more after hospital admission and that was not incubating at hospital admission, Nice guidance (2014)
- Nitrofurantoin may now be used for patients with UTIs with a GFR of > 45ml/min.

Part of the reason for these changes is to help us to reduce the amount of pip-taz we use in the Trust. We are now seeing increasing resistance to this broad spectrum antibiotic in Yorkshire and reducing its use may help slow the increase in resistance rates.

Conferences

International Forum on Quality & Safety in Healthcare

26 – 28th April, London

More information:

<http://internationalforum.bmj.com/>

Patient Safety Congress, Manchester

4-5th July 2017

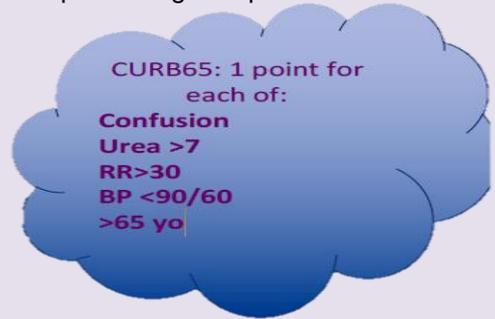
Poster competition: open for submission

<https://www.patientsafetycongress.co.uk/>

Community Acquired Pneumonia – Quality Improvement Project

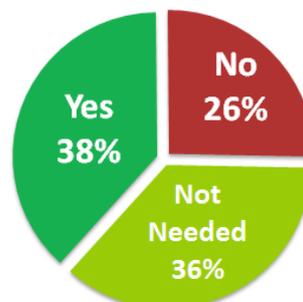
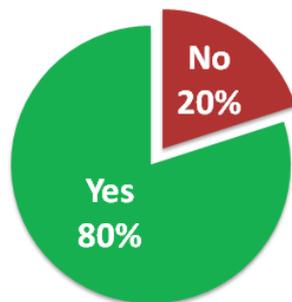
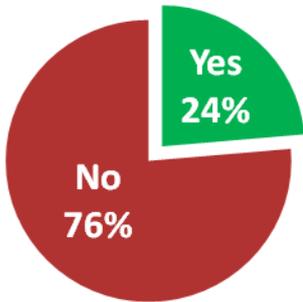
Community Acquired Pneumonia (CAP) accounts for about **22-42% of patients admitted to hospital**. BTS² and NICE¹ have produced guidelines for assessing, risk stratifying and treating patients presenting with pneumonia. Of the 137 recommendations, we selected to audit five of them in York Hospital:

- 1) Vital signs performed within 1 hour of admission
- 2) CXR performed within 4 hours of admission
- 3) Oxygen assessment prescribed on admission
- 4) CURB65 score documented on admission (CURB65 calculated correctly)
- 5) Antibiotics prescribed within 4 hours of admission (and prescribed correctly in accordance with risk stratification and clinical need).



The audit was a retrospective review of the case-notes of patients admitted with pneumonia between November 2015 and February 2016 against the BTS national standardized pro-forma. The inclusion criteria were all admissions between this time period aged 18-75 years old who were coded at discharge as "Community Acquired Pneumonia" and "Lobar or atypical pneumonia". We audited a total of 55 patients, of which 53 had physiological observations within 1 hour of arrival in hospital.

Was a CURB65 Score Recorded? Antibiotics Prescribed Within 4 Hours? Oxygen Prescribed within 1 hour of Admission?



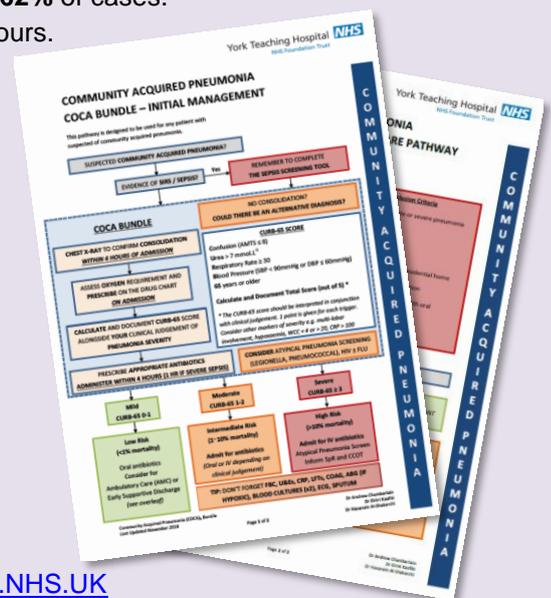
26% of the cases audited did not have oxygen prescribed in accordance with the national guidance.
7% of patients did not have a CXR performed within 4 hours of admission.
 The CURB65 score was calculated in **24% of the patients, correctly in 62% of cases.**
20% of the patients audited did not have antibiotics prescribed within 4 hours.
55% of patients had the correct antibiotic prescribed in accordance with the national guidance.

Interventions:

In order to increase our compliance with the BTS/NICE guidelines and help facilitate early discharge or ambulatory care management where appropriate, we have:

- 1) Introduced the COCA care bundle
 - CXR within 4 hours
 - Oxygen assessment and prescription
 - CURB65 score
 - Antibiotics
- 2) Developed an ambulatory care pathway for CAP

Andrew Chamberlain, ST4 Anaesthetics, Andrew.Chamberlain@YORK.NHS.UK
Eirini Kasfiki, ST6 Acute Internal Medicine, Eirini.Kasfiki@york.nhs.uk
Hassan Al-Shakerchi, Consultant Acute Physician, Hasanain.Al-shakerchi@york.nhs.uk
 Acute Medical Unit, York Hospital,



References:

- ¹ <https://www.nice.org.uk/guidance/cg191>
- ² <https://www.brit-thoracic.org.uk/guidelines-and-quality-standards/community-acquired-pneumonia-in-adults-guideline/>

Quality Improvement Tips - Measures

Measurement is a critical part of testing and implementing changes; measures tell a team whether the changes they are making are actually leading to improvement.

There are 3 kinds of measures:

Outcome Measure - How does the system impact the values of patients, their health and wellbeing? What are impacts on other stakeholders such as payers, employees, or the community?

Example: *Average hemoglobin A1c level for population of patients with diabetes*

Process Measure - Are the parts/steps in the system performing as planned? Are we on track in our efforts to improve the system?

Example: *Percentage of patients whose hemoglobin A1c level was measured twice in the past year*

Balancing Measure - Are changes designed to improve one part of the system causing new problems in other parts of the system?

Example: *For reducing patients' length of stay in the hospital: Make sure readmission rates are not increasing*

For further tips visit the [Institute for Healthcare Improvement website](#). There is also a range of local and regional quality improvement courses available – please email me for more information.

William Lea, IHI Improvement Coach William.lea@york.nhs.uk

Enfit - Enteral feeding equipment

Enfit is the new design for all connectors on enteral feeding equipment, which includes nasogastric, PEG, jejunostomy and gastrostomy tubes, buttons and all other enteral feeding tubes, syringes and giving sets. 'Enteral' in this case refers to 'non-oral'. Enfit is the global enteral feeding device connector design that complies with the new International Standard (ISO 80369-3).



The Enfit connectors are being introduced to prevent any other equipment being attached to enteral feeding equipment and vice versa, for example IV syringes and giving sets. This is part of an international drive to improve patient safety for those who receive enteral nutrition.

All stock across sites will be changed over to the Enfit compatible equipment during the week commencing 27th February. Patients who require enteral feeding in the community will also receive the new equipment. All old stock will be removed during the changeover process, therefore after 3rd March, all equipment will be compatible.

When prescribing, please ensure the route of administration for any liquid medicines (e.g. NG/PEG) is clearly stated, as Enfit compatible medicine syringes will be required for those patients requiring enteral feeding.

For further information, please contact **Bernadette Eivers** Head of Patient Safety – Tel: 772 5133



Spot Diagnosis - Answers

A Loosers Zones (Source:hubpages.com/health) **B Retinoblastoma** (source:oculist.net) **C Meadowsweet** – from which **salicylic acid** can be derived and forms part of the history of **aspirin** production. (source Wikipedia).

Send your 'spot diagnosis' pictures to PatientSafetyMatters@york.nhs.uk

Group Representation

We are working to **empower** and **support** junior doctors to attend and **contribute** to Trust level meetings. Junior doctors and groups will benefit! The following groups are looking for junior representation:

- **EPMA (Electronic Prescribing)**
- **HIPCG (Infection Prevention)**
- **Point of Care Testing Committee**
- **Admission Proforma Group**
- **Deteriorating Patient Group**
- **Patient Experience Steering Group**

Contact PatientSafetyMatters@york.nhs.uk for more information or if you want to get involved.

Editorial Team

Michel Zar, Editor (Specialty Doctor Trauma and Orthopaedics), Laura Bamford, Deputy Editor (Dental Core Trainee), William Lea (Improvement Fellow), 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.

Check out www.yorkhospitals.nhs.uk/patientsafetymatters/ for more information