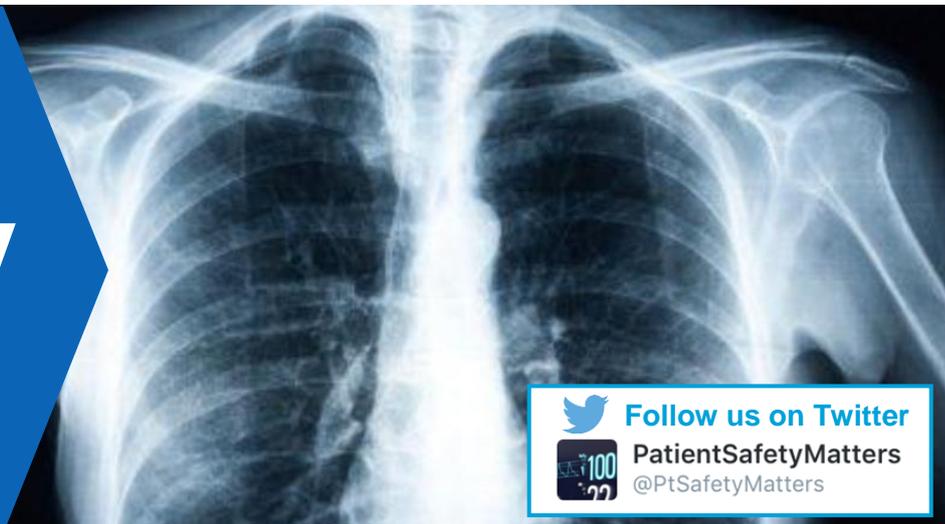


Patient Safety Matters



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PROMOTING A CULTURE OF SAFETY AND QUALITY AMONGST JUNIOR DOCTORS

ISSUE 13 – March 2017

Stepping towards safety with a walk round

Ever heard of a patient safety walk round? You may be surprised to learn that there is one taking place almost every other week somewhere in the Trust.

So what is a walk round? A walk round is when our Trust directors and managers attend clinical areas to meet the respective teams. Rather self-explanatory in that the team walk around the area of interest, with patient safety and care quality being demonstrated. The goal of the walk round is to ensure safety is an on-going priority; and to allow frontline staff to make senior managers aware of patient safety issues.

Why meet in the department? This allows immediate advice to be obtained and safety issues discussed at the highest level. The department staff and managers can speak directly which strengthens hospital-wide relations. It provides an opportunity to build invaluable working relationships with colleagues (instead of emailing someone you have never met), and lends itself towards a shared leadership idea. Walk rounds can take place anywhere including wards, outpatient departments and theatres.

What's the benefit? The department staff can show how improvements have been made and demonstrate good practice. This may be a practical step, which can be seen during the walk round. There is new opportunity to highlight good patient care. Hospital managers gain a hands-on perspective as to how a department functions, and overall stronger relationships can be established. Any concerns can be approached and discussed openly – it is not an assessment, rather a proactive way to improve patient care and safety.

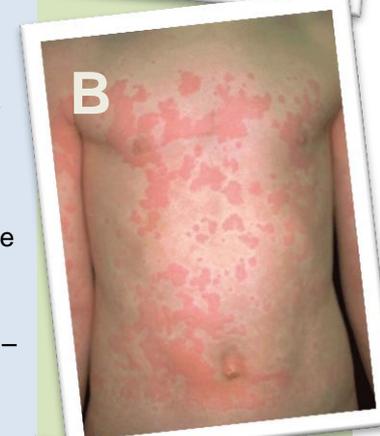
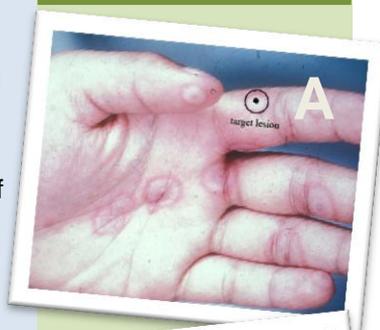
How long does it last? A walk round usually lasts an hour. There is time for an update of matters that were drawn to attention previously, any new concerns, and the chance to share ideas and problem-solve. This is incorporated in to a tour of the department. Any feedback and actions discussed can then be documented and shared with the clinical team and managers.

May I observe? Yes! Anyone with an interest in patient safety can observe a walk round. It is an excellent experience to learn from and reflect upon. It makes you aware that is no substitute for attending a department to understand how it works, realise improvement that has been made, and identify any areas for new change.

How can I find out more? If you would like more information or would like to attend a walk round, please contact Diane Palmer, Deputy Director of Patient Safety (diane.palmer@york.nhs.uk)

Dr Jennie Kuszniir, *Foundation Year One Doctor*, Jennie.Kuszniir@YORK.NHS.UK

SPOT DIAGNOSIS



Answers on the last page. Send us your pictures!

Pharmacy

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

Management of patients following Paracetamol overdose with intravenous N-acetylcysteine (NAC).

Intravenous NAC is effective in preventing liver damage if given within eight hours of a Paracetamol overdose. After this time efficacy falls substantially giving only a very limited window of time to prevent serious hepatotoxicity. Simplified guidance on the management of patients following Paracetamol overdose was implemented in this Trust in September 2012. Following review of this guidance, prescribing information is being updated to advise that continued treatment with NAC may be necessary, depending on the clinical evaluation of the patient.

Hyoscine butylbromide (Buscopan) injection: risk of serious adverse effects in patients with underlying cardiac disease.

Prescribing information on the Gov.uk website has been updated to help to minimise the risk of serious adverse reactions in patients with cardiac disease.

<https://www.gov.uk/drug-safety-update/hyoscine-butylbromide-buscopan-injection-risk-of-serious-adverse-effects-in-patients-with-underlying-cardiac-disease>

Yellow Card reporting added to second clinical software system.

Healthcare professionals who use Vision can now report suspected adverse reactions to the MHRA directly through their clinical software.

<https://www.gov.uk/drug-safety-update/yellow-card-reporting-added-to-second-clinical-software-system>



Medicines & Healthcare
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Learning from our incidents

Allergies

In January there were eight incidents related to patients being prescribed and given medication to which there was a documented allergy, five of these were penicillin. In one of these cases the patient developed a widespread rash.



Remember to **check your patients' allergy status before prescribing any medication**, particularly if you are prescribing penicillin.

There have been reports that prescribers are asking nurses to give medication to patients where there is a documented allergy/sensitivity. We realise that many patients are not truly allergic to a medication so for example may encounter GI disturbance with penicillin but if this is the case this should clearly be documented on the drug chart and on CPD before the nurses are asked to administer the medicines.

Anticoagulants

We continue to receive reports of patients receiving duplicate doses of anticoagulants and prescribers not allowing sufficient time between doses when switching between anticoagulants.



Remember if starting prophylactic LMWH **check the patient is not taking any other anticoagulant** and if starting DOAC, Fondaparinux or therapeutic LMWH, **check for prophylactic LMWH and other anticoagulants**. When switching between anticoagulants:

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 (for AF):	Stop warfarin, wait until INR is under 2.0 before apixaban is started
Warfarin to rivaroxaban (for VTE):	Stop warfarin, wait until INR is 2.5 or under before rivaroxaban is started
If switching from a DOAC to warfarin, or for advice on other DOACs, contact the ward pharmacist, the Anticoagulant clinic (6785) or Medicines information (5960).	

Switching guidance is available on StaffRoom and is displayed in each ward area.

<http://staffroom.ydh.yha.com/policies-and-procedures/clinical/vte-files-to-be-linked/switching-between-anticoagulants-poster>

The IGNAZ App – for junior doctors

The IGNAZ smartphone app has been developed within the Trust to provide junior doctors with access to the latest key clinical information from Staff Room in an easy and simple way.

If you would like to download the app, please email PGME.York@york.nhs.uk

or if you would like to suggest any clinical content please contact Jocelyn.matthews@york.nhs.uk



Escalation of the deteriorating patient

A recent case highlighted the need to identify patients that are not responding to treatment. An elderly lady with numerous co-morbidities was admitted with sepsis secondary to cellulitis. The sepsis six was initiated on arrival to hospital. However she remained hypotensive with a poor urine output for the following 20 hours and there was no senior medical input during this time. Eventually it was recognised that she was not responding to treatment, and she was referred to Critical Care. Sadly despite management in the Intensive Care Unit she died.

Initial recognition and management of the deteriorating patient is crucial, as slow responses and poor management decisions at this time can have huge repercussions. Many simple interventions (such as intra-venous fluids or antibiotics) can be instigated quickly and easily, a delay in starting these measures is associated with worse outcomes for the patient. Reviewing and observing the patient's response to treatment is a key principle in recognising those patients that may require escalation to a higher level of care. Making decisions about escalation of care can be difficult and senior doctors should be involved from an early stage. The Trusts deteriorating patient pathway provides a good framework to base initial responses upon, however there are times when a patient may not hit a specific target NEWS despite a critical deterioration. These patients need to be carefully reviewed and senior staff involved at an early stage if concerned.

In summary:

- Use the NEWS to trigger a timely response and initial intervention
- Review unwell patients to ensure they are responding to management
- Recognise those patients who are not responding to treatment and involve senior colleagues early.

For more information the Deteriorating Adult Patients Monitoring and Escalation Policy can be found on Staff Room;

<http://staffroom.ydh.yha.com/policies-and-procedures/clinical/a-z-list-of-clinical-policies/a-z-integrated-documents/deteriorating-adult-patients-monitoring-and-escalation-policy/view>

Dr Ben Chandler, Consultant Anaesthetist / ICM Scarborough Hospital, Ben.Chandler@york.nhs.uk



Alcohol and Opiate management eLearning

Two new modules designed for all clinical staff, particularly prescribers, are now available on Learning Hub;

Management of Alcohol Dependence and Withdrawal in an Acute Hospital Setting

Completing this module will enable you to; screen for alcohol excess and provide appropriate interventions as clinically indicated; screen, assess and treat alcohol dependency and withdrawal using the 'Alcohol Withdrawal Management Pathway' and refer to the 'Alcohol Misuse: Policy and Procedures for the Identification and Management of Patients'. You will be able to identify and treat Delirium Tremens and Wernicke's Encephalopathy and provide onward advice and referral to specialist services as necessary enabling safe admission and discharge ensuring patient's receive up to date evidence based quality care.

Management of Opiate Dependence and Withdrawal in an Acute Hospital Setting

Completing this module will enable you to identify, screen, assess and treat opiate dependency, toxicity, overdose, and withdrawal using the 'Opiate Dependence Management Pathway' and referring to the 'Drug Misuse: Policy and Procedures for the Identification and Management of Patients'. You will be able to provide onward advice and referral to specialist services as necessary enabling safe admission and discharge ensuring patient's receive up to date evidence based quality care.

To sign-up for either of these modules, visit the Learning Hub on Staff Room, and click on the course title and then the Enrol me button, which will appear underneath the course description. <https://learninghub.yorkhospitals.nhs.uk/auth/saml/login.php>

If you have any queries, please contact the **Substance Misuse Liaison Service** on 01904 726559 or substancemisuselianservice@york.nhs.uk

York Teaching Hospital NHS Foundation Trust

Patient Safety Conference

Friday 9 June 2017 York Racecourse

If you wish to submit an abstract the guidance, template and more information can be found at:

www.yorkhospitals.nhs.uk/psconference2017

Quality Improvement Tips - Change Ideas

All improvement requires change, but not all change is improvement¹. Developing change ideas can be complicated. Although sometimes you might have a hunch about what will work it is often useful to consider the following to ensure that the change ideas you test have the greatest chance of leading to improvement.

1. Logical thinking about the current system

This is about understanding the current structures and processes in your system. Tools can be used to help with this including; flow diagrams, case studies, process maps, and driver diagrams.

2. Benchmarking or learning from others

Has anyone else tackled the problem you're facing? If similar work has been done then think about what you can take from this, but beware of transplanting change ideas from other areas. It is always better to think about 'adapting' rather than 'adopting'.

3. Using technology

This relates to the practical application of science, including equipment, materials, information systems, and methods. Technology can be used to bring about improvement but is often expensive and time consuming to set up.

4. Creative thinking

Creating new ideas can be challenging but there are some tools to encourage and support creative thinking.

Here is an introduction from the Institute for Healthcare Improvement (IHI):

http://app.ihl.org/Events/Attachments/Event-2656/Document-5319/15_Creativity_and_Improvement_Vital_Link_QP.pdf

5. Using change concepts

A change concept is an idea or approach that has been shown to help in developing specific strategies for change that result in improvement. The IHI provides a list of change concepts and this can be found on their website and in the book referenced below.



If you would like to learn more about change ideas and other elements of quality improvement why not check out the IHI open school courses:

<http://app.ihl.org/lms/onlinelearning.aspx>

Try not to lead a project by a change idea, but rather **the aim**; what is it you want to improve? If you lead by a change idea and it fails you might feel the project is over. If you lead by the aim, the project won't be over until you achieve your aim and you can learn and share about what has worked as well as what has not.

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

Reference: 1. Langley et al (2009) The Improvement Guide – A practical approach to enhancing organizational performance (2nd Edition), Jossy-Bass, USA.

Spot Diagnosis - Answers

A - Erythema Multiforme, Source: School of Medicine, University of California, San Francisco

http://missinglink.ucsf.edu/lm/dermatologyglossary/erythema_multiforme.html

B – Urticaria, Source: MSD Manuals

<http://www.msmanuals.com/en-gb/professional/dermatologic-disorders/approach-to-the-dermatologic-patient/urticaria>

C - Kaposi's Sarcoma, Sousa-Squiavinato et al. 2015, Researchgate.net

https://www.researchgate.net/publication/280236231_Biology_and_oncogenicity_of_the_Kaposi_sarcoma_herpesvirus_K1_protein

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 would like 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