I am delighted to be asked to introduce this newsletter and in particular reflect on the role and importance of the Junior Doctors’ Safety Improvement Group. Our junior doctors undoubtedly play a pivotal role in the delivery of our services and the quality and manner in which they are provided, ensuring at all times that we place patients and their needs at the centre of everything that we do. As such I am so pleased that the group is focussing on raising awareness of the patient safety agenda and this newsletter is an important part of this with the aim of promoting a culture of safety and quality primarily amongst junior doctors but also other staff.

This edition contains important updates and case studies and I would urge you to take a look.

Whilst our junior doctors may only be with us for a relatively short time they can bring with them a wealth of knowledge and experience from other hospitals, and equally, take what they learn from our hospitals to their next placement. I am therefore encouraged to see such a focus on patient safety from this important group of staff and I hope many more of our junior doctors will get involved in advocating the importance of this work. My support to the group is unconditional and I wish all involved the very best in their endeavours.

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

Remember nephrotoxic medications in acute kidney injury...

A recent discharge letter reported ‘ARB stopped’ but there was nothing in the letter to say specifically candesartan stopped. The patient had candesartan in his locker and when the TTO was validated the nurses had already given it back to him (along with various other stopped/changed medicines).

Remember the importance of communication.
Make discharge summaries clear.
Be careful with abbreviations.

A recurring theme regarding thickened fluids...

Patients who require thickened fluids aren’t always being discharged with thickening powder. We’re going to ask doctors to prescribe these on the drug chart and ensure they are included in the TTO/Discharge letter.

A reminder about METHOTREXATE...

It may be worth mentioning Methotrexate. In the past there were a couple of incidents where patients had methotrexate prescribed and administered daily instead of weekly. Also, methotrexate was continued in patients with infections when it may have been more appropriate to hold it. Because of this the trust decided that methotrexate would not routinely be given.

METHOTREXATE should be STOPPED on admission in all patients

We had another incident this month where it was prescribed and given (fortunately correctly) but the prescriber said they were not aware of the policy. See the Medicine Matters issue 50 on our site at http://www.yorkhospitals.nhs.uk/patientsafetymatters/

Thanks to Helen Holdsworth and Lynn Ridley for these pharmacy messages.

National DRUG SAFETY ALERTS

A patient was prescribed Posaconazole for a severe fungal infection; tablet form was not available so the prescription was changed to suspension. However, due to differences in bioavailability the dose of liquid should have been increased, the patient took a sub therapeutic dose for 2 weeks which led to moderate harm.

Are people aware that some medicines have different doses when changing between liquid and tablets e.g. Phenytoin, Citalopram and sodium fusidate? Check with your friendly pharmacist if unsure.

(From the national medication safety officer webex)

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

Struggling to find a project to get involved with? Here are some suggestions:

Ceiling of Care Project – There is a relatively new ‘CoC’ button on CPD which allows you to define patients escalation/CPR status. Cardiac arrest audits often show that we could be better at making CoC decisions. Is there a project here?

Lignocaine 1% & 2% - we currently stock both strengths on many wards. Are they both necessary? Could a cost saving and potential patient safety issue be removed?

Methicillin-Sensitive Staphylococcus Aureus (MSSA) – last year the Trust was reported to be an outlier for cases of MSSA bacteraemia. Can you think of ways we might address this?

Get in touch for more information PatientSafetyMatters@york.nhs.uk

PROJECT: Out of Hours’ Warfarin Prescription

Basil Noureldin, Omer Mohammed, Tim Houghton (Scarborough Hospital)

Warfarin is commonly prescribed out of hours. This puts patient safety at risk as doses are delayed or even missed which can result in serious complications such as stroke and pulmonary embolism.

We decided to trial a warfarin folder (on certain wards) where all the warfarin charts are kept to reduce the likelihood of missing charts and facilitate prescribing by one doctor. We involved the ward sisters and placed flyers on wards highlighting the issue and new folders.

Prior to implementing change, only 53.6% of warfarin prescriptions were prescribed in hours. This immediately rose to 83% after implementing the change with a further rise to over 90% over the subsequent weeks.

Further work is being done to determine whether this can be rolled out across wards.

York Teaching Hospital NHS Foundation Trust

Patient Safety Conference

21 June 2016
York University

Our conference was a huge success last year with 320 of our staff attending, over 40 poster presentations and a lively demonstration and exhibition area.

This year we are calling for abstracts for oral and poster presentations, so please encourage your teams to submit their work and attend the conference.

For abstract guidance/submission or more information please visit www.yorkhospitals.nhs.uk/PSconference2016
THINK SEPSIS

Sepsis claims 44,000 lives annually in the U.K, and costs the NHS an estimated £2.5 billion. It can affect patients in any specialty, at any time, whether on admission or whilst an inpatient. We have all seen the consequences and the high morbidity and mortality associated.

Early intervention with the Sepsis Six saves lives, but has also been shown to reduce length of hospital stay and need for HDU/ICU admission.

Effective resuscitation and treatment with appropriate antibiotics will make a difference to our patient’s lives.

Reliable delivery of basic aspects of care early reduces mortality significantly - absolute risk reductions reported range from 16% to over 50%.

Many of you will be aware that for the last year there has been a focus on screening patients at admission and delivering antibiotics within the hour, at the time of admission. There are 2 versions of the screening tool currently – paper and CPD.

Over the coming year there will be an effort across all inpatient areas to improve screening and the delivery of antibiotics in a timely fashion. If anyone has suggestions, comments, ideas or criticisms please share them with me.

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For further reading visit:
The Sepsis Trust
http://www.sepsistrust.org/
Trust Guidelines
http://tinyurl.com/z7ymxxd

GROUP REPRESENTATION

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

- DNACPR
- EPMA (Electronic Prescribing)
- HIPC (Infection Prevention)
- MSG (Medication Safety Group)
- Sepsis
- Deteriorating Patient Group
- Serious Incident Group
- Mortality Steering Group
- Admission Proforma 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)

Follow us on Twitter @PtSafetyMatters
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

For further reading:
http://www.sepsistrust.org/
http://tinyurl.com/z7ymxxd