Patient Safety Matters

PROMOTING A CULTURE OF SAFETY AND QUALITY AMONGST JUNIOR DOCTORS ISSUE 3 - May 2016

ACUTE KIDNEY INJURY - UPDATE

Acute Kidney Injury is an important cause of **mortality and morbidity** in hospital patients, resulting in a cost to the NHS of over **£400,000,000**.

Recommendations by NHS England were to implement **AKI checklist bundles** to aid initial investigation and treatment.

The **first generation AKI checklist** was launched in York Hospital earlier in the year. The checklist is programmed to launch when an AKI is reported in the inpatient care record.

Completion of the checklists was **less than optimal** when analysed.

Feedback from users was that the checklist **was too complex** and had too many components. **As a result the checklist has been amended and simplified**; it will now cover **three main areas**:

1. **Pre-renal - Assessment of NEWS, volume resuscitation and treatment of sepsis.**
2. **Exclusion of obstruction.**
3. **Removal and avoidance of nephrotoxic medication.**

There will also be hyperlinks to useful information such as **hyperkalaemia protocol**, **contrast nephropathy** prophylaxis protocol and **referral advice**.

Usage of the second generation checklist will be analysed and any feedback for continuing development is welcomed – email below.

Dr Ruth Silverton *(ruth.silverton@york.nhs.uk) Renal Team*

20% of patients admitted to hospital have an AKI.

43% of post-admission AKIs have an unacceptable delay in recognition.

Completion rates for the AKI checklist on CPD

40% For Mild AKI (stage 1)

51% For Moderate (stage 2)

60% For Severe (stage 3)

What does LEADERSHIP mean to you? Is it something we are born with? Can you learn to be a better leader?

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PHARMACY

Oral chemotherapy medications should not be prescribed on admission.

A patient was recently prescribed their usual Lenalidomide and another was prescribed Thalidomide and Cyclophosphamide.

Many of these agents are individually dosed for patients and are often given for specific, short courses.

They may **increase the risk or severity of infections** and should not be continued in patients admitted with an acute infection.

These agents should not be given until the dose has been confirmed by an Oncology / Haematology consultant or registrar and they have confirmed that it is appropriate for therapy to continue. The dose confirmation should be written in the patient's notes. For more information visit: http://www.yorkhospitals.nhs.uk/patientsafetymatters/

MHRA UPDATE: SGLT2 inhibitors and the risk of diabetic ketoacidosis

Test for raised ketones in patients with ketoacidosis symptoms, even if plasma glucose levels are near-normal.

Read the full MHRA report for more advice about treating patients who are taking a sodium-glucose co-transporter 2 (SGLT2) inhibitors (canagliflozin, dapagliflozin, or empagliflozin):

http://tinyurl.com/jz3ycqk

Messages from the Venous Thromboembolism (VTE) Committee

A reminder about DALTEPARIN / CLEXANE…

REMEMBER to switch patients back to Dalteparin 5000units s/c (VTE prophylaxis) if their renal function improves. Current guidance is that patients with an eGFR of <30 should be prescribed Clexane 20mg s/c as VTE prophylaxis.

Take care with patients admitted on WARFARIN…

ALWAYS COMPLETE A WARFARIN CHART ON CLERKING FOR PATIENTS ON WARFARIN

It is important to complete a warfarin chart for all patients, usually on warfarin, when they are admitted, even if you are planning to omit warfarin due to high INR levels. Also clearly document your decision regarding VTE prophylaxis. Ensure repeat INRs are requested. A number of patients have gone without warfarin or VTE prophylaxis recently.

*Thanks to **Amy Hicks (FY1) who sits on the committee as a junior doctor representative.***

Learning from errors

(shared from another trust)

Fatal cardiac arrest secondary to low BM following treatment for hyperkalaemia

What happened? A patient with a potassium of 6.3 received 10 units of actrapid in 50ml 10% dextrose. This was repeated on 3 further occasions. There was no BM monitoring. The patient arrested after the 4th infusion and subsequently died. A BM taken during the arrest was 0.6mmol. A venous blood glucose taken 4 hours before they arrested and analysed by pathology was 2.2mmol.

We've had a few incidents in the past with management of hyperkalaemia within the trust and now have a clear protocol and prescription chart to guide staff, this includes the need to check BM after 30 minutes. In addition our path lab would telephone glucose results of <2.5mmol to the ward. **Could this have happened here? Is there anything else we could do?**

*Thanks to **Helen Holdsworth (Deputy Chief Pharmacist)** for this message.*

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

OUALITY IMPROVEMENT

Struggling to find a project to get involved with? Come along to the **Junior Doctor Safety Improvement Group** meetings for ideas. Get in touch and we may be able to help you find a project: **PatientSafetyMatters@york.nhs.uk**

PROJECT: THE JUG ROUND

Cullingworth (HCA), Desborough (Outreach), Knowles (Outreach), Lea (Leadership Fellow), Meggit (ACP), Scott (Outreach), Wagg (HCA), Ward (Sister)

A multidisciplinary team on Ward 25 is working on a project to look at using coloured jug lids to identify those patients at risk of dehydration. Each morning the HCAs will give every patient a jug with a red lid. At intervals during the day the jugs will be checked. When a patient has emptied their jug it will be replaced but with the next colour lid; red, amber, and then green. At 15:00 any patient who still has a red lid on their jug will be flagged up to the nurse and doctor. An assessment can then be made as to whether further investigation or management is required.

We hope this will provide a simple visual system for highlighting patients who may be becoming dehydrated. This project is on-going and we hope to have results soon.

LOOKING FOR A PROJECT?

A recent project in Scarborough found that **only 54% of warfarin was prescribed 'in hours'**. The investigating team introduced a warfarin folder along with staff education on selected wards. **Following this intervention 'in hour' warfarin prescription rose to around 90%.**

We are looking for junior doctor[s] at York interested in carrying out similar work to establish whether a similar intervention can be rolled out here.

Are interested in this quality improvement project? Contact patientsafetymatters@york.nhs.uk

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

INCIDENT REPORTING

We have recently released data to show that reporting rates among doctors is low. Previously we have provided absolute numbers but if we look at incident reports in relation to total staff numbers we still find doctors reporting is significantly lower.

We have been looking at why it is that doctors don't report. Here are some themes:

On reporting incidents:

"No impact breeds apathy and disillusionment."

What would make you report? "Believing it would make a difference"

"the ethos has not moved from the "guilt" syndrome to "learning and education" syndrome."

"no experience of other doctors completing or talking about them"

The electronic DATIX form:

"These electronic forms are a nightmare and need time (which usually one doesn't have) to complete"

"Form has too many drop down boxes that have to be completed whether you know the correct response or not making it difficult to report."

"Choosing names you don't know (eg. Managers of depts.) from an enormous list ranked by surname and not department is tricky."

When we have collected the information we need we will begin to work on ways to overcome the barriers facing doctors and build confidence in the system as a tool for change and improvement. Please get in touch with comments/suggestions.

William Lea, Clinical Leadership Fellow

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)**
- **HIPCG (Infection Prevention)**
- **MSG (Medication Safety Group)**
- **Admission Proforma Group**
- **Deteriorating Patient Group**
- **Serious Incident Group**
- **Mortality Steering Group**

Contact PatientSafetyMatters@york.nhs.uk 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)

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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