

# Patient Safety Matters



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PROMOTING A CULTURE OF SAFETY AND QUALITY AMONGST JUNIOR DOCTORS

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## Developing a culture of safety

We encourage and require all our staff to report adverse events and unsafe conditions. We also encourage them to take immediate action when it is needed and to seek assistance when concerned that the safety of the care being delivered is threatened.

Our aim is to promote an open and just culture. Staff should be aware that they are accountable for their actions; however we want to develop and maintain an environment that feels safe, and where staff recognise that they will not be blamed for system faults in their work environment, beyond their control. Whilst emphasising the importance of avoiding blame we want to move towards a culture that highlights noncompliance with agreed procedures. Failure to follow procedures is often as a result of the process being unwieldy or unsuitable for the environment. We want to focus on improvement of systems.

Patient safety 'Walkrounds' provide valuable, informal opportunities for executive, non-executive directors and senior managers to talk with frontline staff about patient safety issues in the Trust. As a commitment to developing our culture of safety we aim to undertake four 'Walkrounds' each month and to provide a monthly summary report to the Trust Board of Directors. We have recently started arranging Walkrounds to speak to staff working at night and at weekends. The purpose is:

- to help staff become more confident and willing to engage with the safety agenda
- to make senior management more aware of patient and staff safety issues
- to follow up on safety issues quickly and effectively
- to make senior staff more aware of safety issues.

Staff should be reassured that the purpose is not to inspect or interrogate. The purpose is to allow staff to raise patient safety concerns and to discuss with the senior managers of the Trust how patient safety can be improved.

In preparation for participation in a Walkround, and as advised by the Institute of Healthcare Improvement, you may want to think of:

- any events in the past few days that have resulted in prolonged hospitalisation for a patient
- near miss events that almost caused patient harm but did not
- incidents where a patient was harmed
- aspects of the environment likely to lead to a patient harm
- anything that could be done to prevent an adverse event
- a way in which systems or your environment fails you on a consistent basis.

Diane Palmer

Deputy Director of Patient Safety

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## Re-feeding Syndrome can be life threatening

Re-feeding Syndrome (RFS) occurs when malnourished patients are fed with high carbohydrate loads via oral, enteral or parenteral route. The result is a rapid fall in phosphate, magnesium, potassium, glucose derangements and an increasing ECF (Extra Cellular Fluid) volume - causing severe fluid and electrolyte shifts and related metabolic complications.

Re-feeding Syndrome is **preventable** if:

- Patients at risk are identified
- Nutrition is introduced gradually
- Patients are closely monitored
- Biochemical abnormalities are corrected.



Patients who **may be at risk** of re-feeding syndrome include:

- Patients un-fed for 5-10 days, with evidence of stress and electrolyte depletion
- Patients with chronic malnutrition, anorexia nervosa, or evidence of prolonged fasting
- Morbidly obese patients who have undergone significant weight loss
- Patients with a history of alcohol abuse
- Chronic antacid users (antacids bind minerals; therefore levels of minerals may be low)
- Chronic diuretic users
- Oncology patients on chemotherapy.

**Patients are at High Risk of Developing RFS if they have one or more of the following:**

1. BMI <16kg/m<sup>2</sup>
2. Weight loss greater than 15% within the last 3-6 months
3. Little or no nutritional intake for >10 days
4. Low levels of phosphate, potassium or magnesium prior to refeeding

**Or if they have two or more of the following:**

1. BMI less than 18.5 kg/m<sup>2</sup>
2. Unintentional weight loss greater than 10% within the last 3–6 months
3. Little or no nutritional intake for more than 5 days
4. A history of alcohol abuse or drugs including insulin, chemotherapy, antacids or diuretics

If you admit a patient at risk of RFS:

1. Refer to the [Guideline for the Prevention and Management of the Re-feeding Syndrome](#).
2. Contact a [Dietitian](#)
3. Contact a [Gastroenterologist](#), if medical advice needed
4. Order nutrition support baseline bloods (potassium, calcium, phosphate, magnesium & glucose) and nutrition support micronutrients, then nutrition support daily thereafter and correct abnormalities. Nutritional 'order sets' are available on CPD
5. Prescribe oral Thiamine, Vitamin B Compound Strong and a multivitamin as per the protocol (doses in the protocol).

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## Patient consent

**Consent is a patient's agreement for a health professional to provide care.**

Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be recorded), verbally or written. For consent to be valid the patient must:

- be competent to make the particular decision
- have received sufficient information to make it
- not act under duress.

The Department of Health has issued guidance documents on consent, which should be consulted for advice on current law and good practice. Health professionals must be aware of guidance on consent issued by their own regulatory bodies and of the Trust Consent Policy.

Completed copies of consent forms must be filed within the patients notes and the following information recorded on the form:

- evidence that patients have received information leaflets relating to their planned procedure and anaesthetic;
- relevant contact details to allow patients to discuss procedures with clinicians prior to attending the hospital for the procedure; and
- evidence that a copy of the consent form has been offered to the patient.

Consent forms should be re-signed by a health professional to confirm the patient's consent, where this has been signed prior to their planned procedure date.

Only Trust approved consent forms and Patient Information Leaflets from the Trust's current published list should be used.

Helen Noble  
Head of Patient Safety

## 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 doctor 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](mailto:PatientSafetyMatters@york.nhs.uk) for more information or if you want to get involved.

## EDITORIAL TEAM

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

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