Think Sepsis!

Sepsis kills 44,000 people per year with approximately 150,000 cases reported; this can be babies, children and adults who were recently fit and healthy. It can affect anyone, at any time. Early identification and treatment leads to better outcomes¹.

After much discussion, and great input from staff, the rollout of the sepsis trolley will soon begin. Everyone is familiar with the concept of a ‘crash’ trolley; taking the equipment you need, to where you need it. The sepsis trolley will work in much the same fashion. It will include all the equipment needed to screen for severe sepsis and deliver the sepsis six, in the right place at the right time. Some areas already have experience of this and feel it has been of benefit to them.

When the patient at risk of sepsis is first identified the trolley will be taken to the patient bedside/area. In the first drawer will be copies of the screening tool to start the process. The other drawers will contain all the equipment to take bloods, blood cultures, blood gases, give an IV fluid bolus and catheterise if necessary. Antibiotics will still reside in drug cupboards. We need to make sure we work together as a team and communicate so that they are delivered swiftly.

The trollies will be delivered to the ward areas, they are smaller than average so will not clutter up the space. We will provide support in the form of education and training and an SOP has been written.

We are expecting delivery on the 8th Dec in York and 9th Dec in Scarborough so we will soon be delivering better sepsis treatment!

¹http://sepsistrust.org/professional/professional-resources
Mystery doctor writes 25% of all prescriptions

The trust medicines code states that when prescribing:
‘The signature must be legible or the printed name of the prescriber should be written next to the signature, together with a bleep number or another method of contact’.

This is important to ensure there is an accurate record of who prescribed each medicine and also so that pharmacy and nursing staff can quickly contact the prescriber if they have a query about the prescription.

A snapshot audit at Scarborough showed;
18% of prescriptions fully complied with the medicines code;
31% of prescriptions had a legible signature or a printed name;
44% contained the prescribers bleep number;
25% had either no name or legible signature and no bleep or on call bleep number.

Please ensure you identify yourself on all prescriptions, by name and contact number.

BNF issues new advice on oral paracetamol dosing

You probably are aware that the dose of IV paracetamol should be reduced in patients weighing less than 50kg as there is an increased risk of toxicity.

There have been reports of toxicity with ORAL paracetamol in patients with low body weight or with risk factors for hepatotoxicity i.e. alcohol consumption, dehydration, malnutrition, hepatocellular insufficiency. In such cases please consider reducing the dose if oral paracetamol is prescribed.

New MRSA Guidelines

Analysis following cases of MRSA bacteraemia has identified that suppression therapy was not being prescribed or started promptly. The new MRSA guideline involves changes around the way MRSA decolonisation regimes are prescribed and recorded in the Trust. It is a requirement that mupriocin/Naseptin nasal cream is prescribed on the medicine chart in the same way as all other medicines. The chlorhexidine skin and hair washes will be recorded on a dedicated wash record chart which can be found on the IPC Staff Room pages; http://staffroom.ydh.yha.com/policies-and-procedures/clinical/infection-prevention. This allows healthcare assistants, or even the patient themselves, to document that washes have occurred. The pink and yellow stickers previously issued by infection control will no longer be in use. The IPC nurses will be following up these patients daily Mon-Fri to check compliance with suppression regimens.

To view the new guideline in full please visit; http://staffroom.ydh.yha.com/policies-and-procedures/clinical/infection-prevention/mrsa-control-and-prevention-of-policy-v7.0/view

REMEMBER Conference abstract submissions

York Medical Society Founder’s Prize
17/3/2017
Deadline for submission: 9/1/2017
http://www.yorkmedsoc.org/
Email: ymsenquiries@yahoo.co.uk

Patient Safety Congress, Manchester
4-5/7/2017
Patient Safety Awards: open for submission
Poster competition: not opened yet
https://www.patientsafetycongress.co.uk/
Having been inspired by the great work of the Junior Doctor Safety Improvement Group (JDSIG) at York Teaching Hospitals NHS Foundation Trust, we would like to present Junior Doctors Together; a group formed by Junior Doctors to improve engagement, quality and safety across Hull and East Yorkshire Hospitals NHS Trust.

Junior Doctors Together provide a platform to support work and discussion in Quality Improvement, Patient Safety, Audit and Junior Doctor Engagement. We provide the opportunity to meet and network with like-minded colleagues and peers whilst facilitating relationships between individuals, teams and pre-existing systems.

We encourage the sharing of information across the Trust to allow learning from others and avoid duplication and inefficiencies. We provide a reciprocal communication stream between senior management and junior doctors to acknowledge issues or facilitate change by highlighting areas of good and bad practice. Importantly, we provide enthusiastic, innovative individuals the opportunity and support to lead.

Through the backing of our Chief Executive, Mr Chris Long, along with the very supportive team at Medical Education, we launched the group Junior Doctors Together on the 25th August 2016. We have been very fortunate to have the expertise and experience of Dr William Lea (Vice Chair of JDSIG) to support the evolution of Junior Doctors Together in Hull.

We recognise that junior doctors frequently rotate between Trusts which can lead to disengagement. Through the workings and collaboration of the two groups, we hope to improve, sustain and embed junior doctor involvement in Quality Improvement wherever they may work.

We look forward to welcoming future trainees at our meetings when they rotate from York to Hull and vice versa so that staff and patients can ultimately benefit from this improvement culture.

Dr Anna Greenwood & Dr Lizzie Hutchinson,  
Chair & Vice-Chair Junior Doctors Together, Hull  
Follow us and keep updated on Twitter @JDrsTogether

---

**International Forum on Quality & Safety in Healthcare**  
26 - 28 April 2017 | London  

Join over 3,000 colleagues in London for 3 days of ideas, innovation and inspiration. The International Forum aims to empower and encourage participants to be actively involved in shaping the future of healthcare. For further information and to register your place visit [http://internationalforum.bmj.com/](http://internationalforum.bmj.com/). Early bird rates are available until the 30th January 2017.
Nasal-gastric Tube (NGT) placement checking

A training package is available on the learning hub to take all doctors through safe x-ray interpretation of naso-gastric tubes and the correct method to utilise when checking an x-ray. This training only needs to be completed once, doctors will then be able to self-certify that they are competent and will be able to add this to their learning portfolio. This is mandatory for all Foundation Year One Doctors.

To access the training please follow this link to the Learning HUB:

If you have any queries please contact Dr Peter Wanklyn, Consultant Stroke Physician

The NG X-Ray to the left shows an NG in the right lung, this is not safe to feed.
N.B. Incorrect placement and subsequent use of NG tubes is on the never events list.

The IGNAZ App – for junior doctors

A new 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.

The content provides a ‘mini handbook’ with information on teaching contacts and support as well as Trust guidance and guidelines for common medical conditions when on-call. There are over 110 clinical documents (including 15 medical scoring systems) in 23 categories which have been recommended by junior doctors. Initially Dr Charlotte Stephenson, a Quality Improvement Fellow worked on the app, but now Dr Aesha Mohammed, a Leadership Fellow in Paediatrics will be providing paediatric content over the next few months.

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

SPOT DIAGNOSIS - Answers

A – Air under the diaphragm, B – Amiodarone toxicity, C – Gout of metatarsal-phalangeal and interphalangeal joints of the big toe

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

This months spot diagnosis pictures were taken from the ‘Faculty of Medicine Blog Spot’ which can be accessed via the following link:
http://facultyofmedicine1.blogspot.co.uk/2010/09/what-is-your-medical-diagnosis-34.html

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)
- HICPG (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

William Lea (Improvement Fellow), Diane Palmer (Patient Safety), Michel Zar (Specialty Doctor Trauma and Orthopaedics), Laura Bamford (Dental Core Trainee), 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