Infection prevention case study: Just another cannula?!

A 77 year old man with dilated cardiomyopathy and a cardiac resynchronisation therapy (CRT) device in situ presented with heart failure and was admitted for intravenous (IV) furosemide. A month into his admission he developed severe sepsis secondary to a cannula site infection. Documentation of cannula insertions and checks throughout his admission had been poor. Peripheral blood cultures and pus from the infected cannula site grew Methicillin-resistant Staphylococcus aureus (MRSA). He was source isolated, commenced on MRSA decolonisation and treated with 14 days of antibiotics (Vancomycin followed by Linezolid).

A month later the patient was readmitted following a fall. His blood cultures once again grew MRSA raising concern for infection of the CRT device. He was commenced on IV Vancomycin and MRSA decolonisation. The infected CRT device was removed and MRSA isolated from the leads and pocket site. As a result of removing the CRT device the patient’s heart failure worsened and he died.

Learning points:

• Cannula site infections readily allow bacteria to enter the blood stream which can cause sepsis and result in bacteria attaching to and infecting in-dwelling prosthetic devices.

• A decision to use a cannula in a patient with such devices requires careful consideration and scrupulous attention to best practice in their use.

• Cannula associated infections can be avoided by:
  - Only inserting cannulas when clearly indicated
  - Using aseptic non touch technique (ANTT) when inserting
  - Secure cannulas with appropriate cannula site dressings and replace if they are loose or contaminated. Do not use bandages, which obscure view of insertion site.
  - Observing the cannula site twice a day to look for signs of infection, completing the VIP (Visual Infusion Phlebitis) score as shown below. Record the result on CPD.
  - Remove cannulas as soon as they are no longer needed or if VIP >/=1
  - Record cannula insertion and removal on CPD.

Further information on completing a VIP Score on CPD is available via this link

Alison Prescott, Specialty Trainee (ST4) Microbiology, Alison.Prescott@YORK.NHS.UK
Discharge prescriptions

The CCG conducted an audit in 2016 which showed that 10% of discharge prescriptions had errors or discrepancies, which included:

- Incomplete information as to why medication has been stopped/started or changed
- A lack of clarity as to if medication has been stopped intentionally or accidentally omitted from the discharge prescription.

It can be challenging to write a discharge prescription, especially if under pressure and you don’t know the patient. One suggestion is that when stopping medication or changing the dose you document the reason on the prescription chart or if starting a medication you document the indication in the additional instructions box. That way, the information is at hand for the person writing the TTO, making their task much simpler.

Those of you working at York Hospital will be aware of the role out of electronic prescribing where it will be mandatory to complete these fields.

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

Royal College of Nursing and British Geriatrics Society Joint Conference

Our Quality Improvement Project to improve the identification of delirium on the Acute Medical Unit at York Hospital has been in progress for almost a year. In order to demonstrate our work and share with others, we submitted an abstract to the Royal College of Nursing Older People's Forum and British Geriatrics Society Joint Conference. The abstract was successfully accepted for poster presentation. The conference took place on 20th September at the Royal College of Nursing Headquarters, Marylebone, London.

We were one of only eight poster presentations at the event, which was sold out with over 200 delegates attending. These included doctors, staff nurses, matrons, ward managers and care home owners.

We were given the opportunity to present during the morning and afternoon breaks, and over lunch. We were delighted to receive interest from a wide range of professionals, who were impressed with the concept and content of the project, design of the poster, and our enthusiasm. We enjoyed talking through our work, and were able to invite and answer questions. Many noted that it was a very worthwhile and important project. We received very positive feedback and have, since the event, been contacted by several interested delegates.

The talks on the day were excellent, with key topics of frailty, dementia and falls. To hear how other teams from around the country have worked to improve services, despite constraints, was very inspiring.

We heard how a team in the Wirral had developed an older person’s assessment unit, to improve identification and timely management of frail patients, reduce length of stay, and reduce the wait for social care when medically fit. We attended presentations on falls prevention and preventing deconditioning. A team from Surrey discussed how they were educating nursing and medical students about dementia, and a Nottingham group presented their work on dementia communication skills training.

It was an educational and enjoyable day and a fantastic opportunity to display our work.

Check out the project poster [here].

Dr Jennie Kusznir, Foundation Year 2 Doctor, Jennie.Kusznir@YORK.NHS.UK and Dr Amelia Bearn, Foundation Year 2 Doctor, Amelia.Bearn@YORK.NHS.UK

The IGNAZ App – for junior doctors

The IGNAZ smartphone app provides access to the latest key clinical information from Staff Room in an easy and simple way. The app is available to download on Staff Room: http://staffroom.ydh.yha.com/Learning-Development-and-Professional-Registration/postgraduate-education/the-ignaz-app-for-junior-doctors or if you would like to suggest any clinical content please contact Jocelyn.matthews@york.nhs.uk
Learning from Deaths – New Process

A CQC review in December 2016, ‘Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England’ found that some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care.

In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.

The previous Trust Policy of initial reviews by the treating consultant will continue with a new proforma which includes a rating for overall care. If concerns about care have been raised, for instance through an incident report (DATIX), and is deemed a serious incident it will be investigated according to the Serious Incident Policy as the primary approach. If the treating consultant thinks the overall care has been poor then a second level review called a **Structured Judgement Casenote Review (SJCR)** will be commissioned. This will be performed by an independent consultant who has been specifically trained in the methodology.

Training is available in the Trust and information about the process is available at: [https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcr-rr-programme-resources](https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcr-rr-programme-resources)

There are also some patients who will automatically require a SJCR. These include:

- patients with learning difficulties or severe mental health problems
- patients who die after elective admission
- patients whose relatives or carers raise serious concerns about the treatment they received.

The bereaved relatives will be informed that this process is ongoing and will have a right to have a summary of the report. These SJCRs aim to identify good and substandard practice and this is scored and described. The Trust has a **Mortality Steering Group (MSG)** who coordinate this work. Each Directorate Governance Lead has a crucial role in this work linking with the MSG. Clear action plans will be developed in response to any poor care identified.


If any support is required or any concerns are raised about this process then please do contact;

**Dr. Peter Wanklyn, Consultant Stroke Physician**, Peter.Wanklyn@york.nhs.uk

**Helen Noble, Head of Patient Safety**, Helen.Noble@york.nhs.uk

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### Accessing Library Resources

The easiest way to find out what books are available from the Trust library service is to search the online catalogue at [http://bit.ly/1DrTx5X](http://bit.ly/1DrTx5X)

We also offer a document supply service for any books or journals not held within the library. Request forms are available at [http://staffroom.ydh.yha.com/Learning-Development-and-Professional-Registration/library/guides-and-forms/forms](http://staffroom.ydh.yha.com/Learning-Development-and-Professional-Registration/library/guides-and-forms/forms) or paper forms are available in the library.

For access to free national and regional NHS databases and journals at [https://www.nice.org.uk/about/what-we-do/evidence-services/journals-and-databases](https://www.nice.org.uk/about/what-we-do/evidence-services/journals-and-databases) you will need and NHS Open Athens account. To register go to [https://openathens.nice.org.uk/](https://openathens.nice.org.uk/)

You will also need this account to access UpToDate off site.

If you want refresher training on how to search the databases or look for articles contact the Clinical Librarians at either site at library@york.nhs.uk
Quality Improvement Tips – Setting your aim

Setting a strong aim is vital to the success of an improvement project. Anyone reading your aim should be able to understand what it is you are trying to achieve; how much, by when, where, for whom and why?

The SMART tool provides some important considerations:

**Specific** - The aim is well-defined and clear, giving it a better chance of being reached than a general aim.

**Measurable** - Objectives should have a benchmark and target, to help determine when objectives are achieved.

**Achievable** - The aim is something that can actually be reached.

**Relevant** - The aim is relevant to your team or the organisation’s needs, visions, and goals, and is agreed-upon by stakeholders.

**Timely** - The aim has a set time-frame to be met.

**Examples of some good aims:**

- ‘Reduce adverse drug events (ADEs) in critical care by 20% within 1 year.’
- ‘Achieve > 95% compliance with on-time prophylactic antibiotic administration within 1 year.’

For further tips visit the Institute for Healthcare Improvement website. There is also a range of local and regional quality improvement courses available – please email me for more information.

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

References


Online Quality Improvement Training

The Improvement Academy have developed an e-learning Bronze training programme which includes a broad spectrum of foundation knowledge, from an introduction to the concepts of quality improvement and the Model for Improvement, to more detailed descriptions of some of the tools for improvement and how they can be used. This can be accessed for FREE via the following link;


21st November Junior Doctors Safety Improvement Group

Ophthalmology Seminar Room York and Orchard Room Scarborough

All welcome

Spot Diagnosis - Answers

- **A Thyroglossal Duct Cyst** - [http://facultyofmedicine1.blogspot.co.uk/2010/11/what-is-your-medical-diagnosis-226.html](http://facultyofmedicine1.blogspot.co.uk/2010/11/what-is-your-medical-diagnosis-226.html)
- **B Periodontal Disease** - [http://facultyofmedicine1.blogspot.co.uk/2010/12/what-is-your-medical-diagnosis-228.html](http://facultyofmedicine1.blogspot.co.uk/2010/12/what-is-your-medical-diagnosis-228.html)
- **C Basal cell carcinoma** - [http://facultyofmedicine1.blogspot.co.uk/2010/12/what-is-your-medical-diagnosis-254.html](http://facultyofmedicine1.blogspot.co.uk/2010/12/what-is-your-medical-diagnosis-254.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! Contact [PatientSafetyMatters@york.nhs.uk](mailto:PatientSafetyMatters@york.nhs.uk) for more information or if you would like to get involved.

Editorial Team

Michel Zar (Specialty Doctor Trauma and Orthopaedics), Laura Bamford (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](mailto:PatientSafetyMatters@york.nhs.uk) if you have any comments or would like to contribute. Check out [www.yorkhospitals.nhs.uk/patientsafetymatters/](http://www.yorkhospitals.nhs.uk/patientsafetymatters/) for more information.