New Guideline - Best Interest Feeding in Adults

Ensuring adequate nutrition/hydration is a key step in aiding patients, within the acute care setting, to return home. Unfortunately some patients are at risk of choking on food/fluid and developing aspiration pneumonia due to an oral or pharyngeal stage dysphagia. Such patients are often deemed unsuitable for alternative nutrition or hydration and therefore the best option for them may be to continue with oral intake despite the risks.

Previously referred to as ‘comfort feeding’ or ‘feeding with accepted risk’, the recently launched **Best Interest Feeding Guidelines for Adults** aims to guide teams through an organised decision making process, encompassing patient choice and multidisciplinary clinical input in what can be an ethically complex area.

A structured flow chart of the steps to follow in such cases is included.


Further advice and support can be sought from the Adult Speech & Language Therapy Department at York or Scarborough on 01904 725768.

**Helena Perry**, Team Leader (York) & Advanced Clinical Specialist SLT in Dysphagia, [Helena.Perry@york.nhs.uk](mailto:Helena.Perry@york.nhs.uk)
SAFE Steroid Prescribing in Palliative Care

In 2015 a patient died from sepsis after receiving 16mg of dexamethasone a day for 5 weeks. The coroner felt that the prolonged high dose steroid course had contributed to the development of pneumonia and the patients’ rapid decline. One of the recommendations, from the Serious Incident (SI) investigation, was that the Trust should produce guidance on steroid prescribing in palliative care, which are now available on Staff Room, and that the indication for steroids should be recorded along with a plan as to when the dose should be reviewed.

An audit earlier this year showed that the guidelines were not been followed in 59% of cases and the indication for treatment was only recorded in 9% of patients. Only 43% had a date where the therapy should be reviewed. On discharge only 61% of patients had a clear plan in place for review of the steroids.

**16mg of Dexamethasone is equivalent to 100mg of Prednisolone.**

Steroids may be used in palliative care for symptom control and Dexamethasone is the usual choice. There are many indications for steroid use such as malignant spinal cord compression and liver capsule pain. Each indication has a suggested starting dose and further guidance on this can be found in ‘Steroid Prescribing in Palliative Care: Key Messages’ on the Trust website [https://www.yorkhospitals.nhs.uk/seecmsfile/?id=2343](https://www.yorkhospitals.nhs.uk/seecmsfile/?id=2343).

**Steroids can have serious side effects such as diabetes mellitus, increased susceptibility to infections and significant myopathies.**

Here are some tips for safe steroid prescribing in palliative care:

1) Clearly document indication and plan for review/down-titration
2) Keep to short courses and lowest effective doses
   - Review after 5 days – if no benefit – stop them
   - If there is benefit then reduce to lowest dose that sustains benefit
   - Limit course to <3 weeks if possible and dose can be tapered fairly quickly within this duration
   - Longer course, >3 weeks, will need more prolonged tapering
3) Consider a PPI for duration of steroid course
4) Check sugars - There is further guidance on blood sugar monitoring and control in ‘Steroid Prescribing in Palliative Care: Key Messages’ on the Trust website [https://www.yorkhospitals.nhs.uk/seecmsfile/?id=2343](https://www.yorkhospitals.nhs.uk/seecmsfile/?id=2343).
5) Safe discharge
   - DO NOT discharge patient on steroids without a clear plan
   - Discharge letters should provide:
     - Plan for steroid reduction/review
     - Clear designation of who is responsible for this
     - Time frame for course and reduction/review

Remember to educate the patient on the risks and benefits of steroids and provide a steroid card.

If you are unsure, please seek advice from treating team, diabetes team or palliative care team:

**Diabetic specialist nurses:** Scarborough 01723 342274, York 01904 724938

**Hospital palliative care team:** Scarborough 01723 342446, York 01904 725835

**Community palliative care team:** Scarborough 01723 356043, York 01904 724476
National HIV testing week

As we approach national HIV testing week (starting on Saturday 18th November), we are attempting to increase awareness of indications for HIV testing amongst our hospital inpatients in order to increase our rate of testing. Data from Public Health England (2015) indicates that around 1 in 8 people currently living with HIV in the UK are undiagnosed, and are therefore at risk of transmitting the disease to others.

The latest data shows that 69% of patients diagnosed with HIV in York are diagnosed late (CD4 count <350), well above the national average of 39% and the highest proportion of late diagnoses in the Yorkshire and Humber region. Late HIV diagnosis is associated with increased mortality, poorer response to treatment, increased risk of transmission and increased healthcare costs. If we can detect these cases earlier and prevent onward transmission, we can save approximately £380,000 per transmission prevented and save many lives and much suffering.

Current British HIV Association (BHIVA) and NICE guidance states that HIV testing should be offered to all patients presenting for healthcare where HIV, including primary infection, enters the differential diagnosis. This includes all patients with an ‘indicator condition’, which include:

- Community-acquired pneumonia
- Memory change
- Unexplained weight loss/chronic diarrhoea
- Non-specific ‘viral illness’

The full list of indicator conditions are shown in the ‘Saving Lives’ leaflet, available at: [http://www.savinglivesuk.com/resources/clinical-indicator-leaflets/](http://www.savinglivesuk.com/resources/clinical-indicator-leaflets/)

Verbal notification that the test is being done is required, written notification is not needed, and current guidance recommends that the test is requested routinely along with other bloods.

For more information, please see [https://www.yorkhospitals.nhs.uk/seecmsfile/?id=2266](https://www.yorkhospitals.nhs.uk/seecmsfile/?id=2266)

Samuel Simpson, Academic FY2 in HIV/GUM, York, Samuel.Simpson@YORK.NHS.UK
Fiona Wallis, Lead Nurse in HIV, York and Scarborough, Fiona.Wallis@York.NHS.UK

Prescribing intravenous fluids for ADULTS

There is a new Intravenous fluid prescription chart for ADULTS which is to be used in most areas of the Trust; exceptions are documented on the chart. The chart has been redesigned to concord with NICE guidelines for prescribing intravenous fluids and improve Trust compliance with these guidelines.

The guidance should be self-explanatory but a brief outline is given below;

1. Assess the Patient
2. Decide why you are prescribing intravenous fluids - are they for resuscitation, for replacement of abnormal losses, or for maintenance of hydration in someone that cannot take fluids enterally?
3. Record the indication for prescribing intravenous fluids when writing your prescription
4. When prescribing maintenance fluids use an appropriate fluid and rate for the patients weight
5. When prescribing resuscitation fluids reassess and seek senior (SpR or above) advice sooner rather than later
6. Complete all parts of the prescription accurately
7. The chart includes other advice - please use it; if in doubt ask a senior medical colleague
8. SENIOR DOCTORS LEADING WARD ROUNDS – intravenous fluids should be reviewed daily and the outcome of that review recorded in the medical notes. This review should include the indication for continuing intravenous fluid in your patient.


Colin Jones, Consultant Physician and Nephrologist, Colin.Jones@york.nhs.uk
Quality Improvement Tips – Measurement

Measurement is a critical part of testing and implementing changes; measures tell a team whether the changes they are making are actually leading to improvement.

There are 3 kinds of measures:

**Outcome Measure** - How does the system impact the values of patients, their health and wellbeing? What are the impacts on other stakeholders such as payers, employees, or the community?

**Example:** Average hemoglobin A1c level for population of patients with diabetes

**Process Measure** - Are the parts/steps in the system performing as planned? Are we on track in our efforts to improve the system?

**Example:** Percentage of patients whose hemoglobin A1c level was measured twice in the past year

**Balancing Measure** - Are changes designed to improve one part of the system causing new problems in other parts of the system?

**Example:** For reducing patients' length of stay in the hospital: Make sure readmission rates are not increasing

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

Organisational Development & Improvement Learning (ODIL)

The Trust ODIL Team teach techniques and how to use tools that help staff review the way services are run and make positive changes using improvement methodology. The following opportunities are available;

**Introduction to Quality Improvement**

This half day session provides a basic awareness and understanding of Quality Improvement thinking, tools and techniques. It will provide sufficient understanding to mobilise change in your area.

**Quality Improvement Workshop**

This workshop of Quality Improvement tools and techniques supports staff leading or driving small improvement projects or change ideas. The workshop is designed so delegates can mobilise change by applying the exercises and thinking to their own improvement project/change idea. Delegates will return to their group to share their learning through the delivery of a 10 minute talk 5-6 months later.

For more information or to add your name to the waitlist for these courses, visit the ODIL page on Staffroom [http://staffroom.ydh.yha.com/Learning-Development-and-Professional-Registration/organisational-development](http://staffroom.ydh.yha.com/Learning-Development-and-Professional-Registration/organisational-development) or e-mail the ODIL team at: ODIL.Request@york.nhs.uk

Spot Diagnosis - Answers

A - Pelvic Lipomatosis - [http://facultyofmedicine1.blogspot.co.uk/2010/12/what-is-your-medical-diagnosis-229.html](http://facultyofmedicine1.blogspot.co.uk/2010/12/what-is-your-medical-diagnosis-229.html)
B - Lyme disease - [http://facultyofmedicine1.blogspot.co.uk/2010/11/what-is-your-medical-diagnosis-223.html](http://facultyofmedicine1.blogspot.co.uk/2010/11/what-is-your-medical-diagnosis-223.html)
C - Pagets Disease - [http://facultyofmedicine1.blogspot.co.uk/2010/11/what-is-your-medical-diagnosis-222.html](http://facultyofmedicine1.blogspot.co.uk/2010/11/what-is-your-medical-diagnosis-222.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 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 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.