JOY AT WORK

What is joy and why does it matter?
The Merriam-Webster Dictionary defines joy as ‘the emotion evoked by wellbeing, success, or good fortune or by the prospect of possessing what one desires’\(^1\).

A report commissioned by NHS Employers into staff experience and patient outcomes (satisfaction and health) concluded there was enough data to support links between improved staff experience and better patient care\(^2\).
The Institute for Healthcare Improvement (IHI) lists 3 benefits of a happy workplace. Joy leads to more empathic care and innovative solutions with which to deliver it. It’s a key component of Deming’s theories around intrinsic motivation and pride in workmanship. It reduces burnout (which should improve retention and recruitment of staff).

In summary, poor staff satisfaction has links to poor patient care whilst reducing the chances of staff developing ideas or engaging with change.

How to bring about joy?
The IHI takes a 4-step approach beginning with asking staff, “What matters to you?”\(^3\) The key element is to show people you are responding to what they have told you.

The Happy Manifesto has 10 core principles the first of which is ‘Trust your people’\(^4\). Without it staff feel undervalued and stifled. This in turn cages innovation and demotivates. Giving constructive and positive feedback, not simply at annual appraisals, boosts staff morale. Embrace a no-blame culture and support learning from mistakes.

These aren’t novel suggestions but how meaningfully do we employ them. You may remain unconvinced but remember, at the end of the day, happiness is free. In these times of austerity can we afford not to make it our focus with so much to potentially gain?

References:

Ruwani Rupesinghe, Chief Registrar, Ruwani.Rupesinghe@YORK.NHS.UK
Delirium – Introducing a new assessment & pathway

What is Delirium? Delirium is an acute decline in mental functioning with confusion, over activity or underactivity and distress (hallucinations, paranoia). It is usually caused by acute medical illness, surgery, or by medicines or medication withdrawal. Most patients recover in a few days to a few weeks. Delirium is not the same as dementia, which is chronic and generally irreversible.

Where in the hospital is delirium most common? 15% of adult acute general patients; 30% acute geriatric patients; 50% ICU patients; 50% post hip fracture surgery.

Why is delirium serious? Delirium is distressing for patients and families; 1 in 5 patients die within one month; it increases the risk of falls and other complications and increases the risk of new institutionalisation.

What is the treatment for delirium? Treatment is often prolonged and complex and involves early treatment of underlying medical causes, plus treatment of distress and other features of delirium itself.

Who can assess for delirium? Any member of staff involved in the care of a patient over the age of 65 can assess for delirium, including Healthcare Assistants, Physiotherapists or Consultants.

When should you assess? When any patient over the age of 65 seems confused, not themselves, quieter than usual, agitated, or if the family think they have been confused.

How do you assess? The 4AT assessment is a simple tool involving 4 questions to help determine if someone has delirium. 4AT assessment stickers will soon be available in clinical areas throughout York and Scarborough Hospital. If the score of the assessment is 4 or more your patient may have delirium, place the Delirium Pathway in the notes and inform the rest of the team involved in the patients care.

Should I Refer? If you have a patient with delirium and you are struggling to manage them you can refer them to the MHALT team via CPD

I need Help! The following are sources of help or support:

For questions about the project contact William Lea, Improvement Fellow, William.lea@york.nhs.uk

York:
9 - 5 Mon-Fri if the patient is on the wards & over 65 years old: Mental Health Assessment & Liaison Team (MHALT) on ext 4040
Out of hours/public holiday call: Liaison Mental Health Team (LMHT) 07852-527583 or via Switchboard for any patients at the Emergency Department

Scarborough:
9 - 5 Mon-Fri: Liaison Mental Health Team 01723 342663
Out of hours – Crisis Team 01723 384645

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

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 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 you will need and NHS Open Athens account. To register go to 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.

For any queries on any of the above information please contact the library at library@york.nhs.uk
**Harmonisation of Enteral Feeding tubes for NG/NJ feeding**

**Approaches to improve safety: Standardisation**

In health care, evidence shows that “divergent patterns of care result in worse clinical outcomes and that removal of variance can reduce risk, inefficiencies and costs⁴”; by standardising equipment and processes we can reduce risk and improve safety. Here is a recent example of local standardisation:

Nasoeenteric tubes are routinely used for enteral feeding for inpatients with a functioning gut who cannot be fed orally, or are unable to manage sufficient nutrition by mouth. They can be placed via the nose into the stomach (Nasogastric tube) or into the small intestine (Nasojejunal tube) for delivery of nutrients.

There are many different brands of nasoeenteric feeding tubes, and they are available in a wide range of diameters and lengths. Previously different brands of nasoeenteric tubes have been used for feeding at York and Scarborough hospital sites.

After discussion with relevant clinicians and healthcare professionals the Nutrition Steering Group (NSG) has approved a proposal that the range of nasoeenteric tubes stocked will be harmonised across both sites. Old stock has been removed and redistributed to the relevant clinical areas.

There will now only be 3 nasoeenteric tubes available on the wards:

- The Corflo 8 French 91cm nasoeenteric tube will be used for fine bore nasogastric feeding as first line and will be stocked on all wards.
- The Corflo 12 French 91cm nasoeenteric tube will be used on critical care (ICU) as first line for nasogastric feeding, where there is a requirement for aspirating the stomach contents to measure gastric residual volumes and assess feed tolerance. These will also be stocked on selected surgical wards (wards 14 and 16 at York, and Maple at Scarborough).
- The Corflo 8 French 140cm nasoeenteric tube will be used for radiologically inserted nasojejunal feeding and will be stocked on selected surgical wards (wards 14 and 16 at York, and Maple at Scarborough).

The above changes should have been implemented at both York and Scarborough hospitals. If you have any queries please contact:

**Gerry Robins**, Consultant Gastroenterologist, [Gerry.Robins@York.nhs.uk](mailto:Gerry.Robins@York.nhs.uk), **Alison Longbottom**, ACS Dietitian for Gastroenterology, Surgery & Critical Care, [alison.longbottom@york.nhs.uk](mailto:alison.longbottom@york.nhs.uk), **Carol Halton**, Matron for Medicine, [Carol.Halton@york.nhs.uk](mailto:Carol.Halton@york.nhs.uk)

**References**


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**Paired Learning Programme**

**What is it?** A peer learning opportunity that buddies doctors and managers together

**Where is it?** York Hospital between February and May 2018

**What happens?** 4 self-directed ‘buddy meetings’ over 4 months 2 group networking sessions

**Why do it?** Along with being an excellent experience, this is an opportunity to learn about managers and how they work, make professional contacts for the future and enhance your CV/e-portfolio

**What do I need to do?** If you are interested please email Dr James Houston at: [mt14jfbh@leeds.ac.uk](mailto:mt14jfbh@leeds.ac.uk). Dr Houston is an ST6 paediatric doctor undertaking this project as part of master’s degree research with the University of Leeds. The research supervisor is Dr Jess Morgan

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**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.
Learning from incidents

Considering VTE prophylaxis on discontinuation of anti-coagulation

A patient was admitted to the hospital who had prophylaxis for venous thromboembolism given for a few days. They were subsequently commenced on anticoagulation for atrial fibrillation; however, it was felt that the risks of anticoagulation outweighed any benefits and it was discontinued. VTE prophylaxis was not recommened at that stage. The patient suffered a cardiac arrest whilst an inpatient and was successfully resuscitated. The team felt a pulmonary embolism was the most likely cause and commenced therapeutic Low Molecular Weight Heparin (LMWH). Unfortunately, the patient deteriorated and died before any further investigations were completed.

This case highlights the importance of **continued review of VTE prophylaxis throughout a patients stay** and not simply on admission.

Additionally, **when discontinuing anticoagulation consider whether prophylaxis is appropriate.** Advice exists on when it is safe to commence medical prophylaxis depending on what anticoagulant was being used. If in doubt, consult your pharmacist.

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Reducing the Risk of Contrast Nephropathy

The incidence of contrast nephropathy can be reduced through the identification of ‘at risk’ individuals and ensuring adequate hydration. Risk can be reduced; it cannot be excluded. An iodinated-enhanced contrast study should only be undertaken where the likely benefit justifies any risk AND the patient is aware of the risk involved. The protocol for contrast nephropathy has changed and key amendments to note are;

- prophylaxis reduces the risk - it does not abolish the risk
- it is the responsibility of the clinician requesting the investigation to identify at risk patients, consider the benefit of the investigation versus the risk and counsel the patient accordingly
- prophylaxis is focused on prehydration with 0.9% sodium chloride ONLY. Intravenous sodium bicarbonate and oral acetylcysteine are no longer included in the protocol.
- Risk of AKI can also be reduced by suspending / discontinuing nephrotoxic medications during the period of illness and investigation


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Spot Diagnosis - Answers

A – Pterygium [http://facultyofmedicine1.blogspot.co.uk/2011/01/what-is-your-medical-diagnosis-281.html](http://facultyofmedicine1.blogspot.co.uk/2011/01/what-is-your-medical-diagnosis-281.html)

B – Xanthelasma [http://facultyofmedicine1.blogspot.co.uk/2011/01/what-is-your-medical-diagnosis-289.html](http://facultyofmedicine1.blogspot.co.uk/2011/01/what-is-your-medical-diagnosis-289.html)

C - Crozon’s syndrome [http://facultyofmedicine1.blogspot.co.uk/2011/01/what-is-your-medical-diagnosis-293.html](http://facultyofmedicine1.blogspot.co.uk/2011/01/what-is-your-medical-diagnosis-293.html)

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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