Patient Safety Matters

PROMOTING A CULTURE OF SAFETY AND QUALITY AMONGST JUNIOR DOCTORS

ISSUE 15 – May 2017

Can we improve the communication between secondary and primary care?

Poor quality information between secondary and primary care can increase the risk of adverse events and admission or re-admission to hospital[1], so it important for our patients that we get this right. When requesting that the GP complete further investigations or follow up, it is crucial that they have a clear understanding of what is required, why and the timescale for completion. The BMA and NHS England have published guidance stating that the doctor requesting a test retains responsibility for the results unless this has been explicitly accepted by the GP [2,3]. Using the SBAR[4] (situation, background, assessment and recommendation) format in written communication with our GP colleagues will ensure understanding of what is expected and why.

When recommending that a medication is started; the dose should be written alongside any monitoring instructions. When a blood test is required; the patient should be given a form clearly indicating who the results should be sent to. When expecting the GP to interpret any blood results; the most recent results should be included in the correspondence.

It is very important that patients are made aware of any further management plans following an outpatient appointment or on discharge from hospital and that this communication should also be noted on any correspondence to the GP. Following a face-to-face consultation, a useful way to communicate results with a patient can be via a letter, for example;

'Your blood test indicated that your iron stores are a little bit low and I would suggest you arrange to see your GP and discuss whether you would need to go on a short course of iron supplement'

These simple rules aim to reduce the risk of medication errors, missing investigation results and misinterpretation of these results. It also ensures we maintain good communication with our colleagues and that there is an effective and safe outcome for the patient

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References

[1]Cresswell A, Hart M, Suchanek O, Young T, Leaver L, Hibbs S. Mind the gap: Improving discharge communication between secondary and primary care. BMJ Qual Improv Rep. 2015;4(1).

[2]BMA. Duty of care regarding communication of investigation results 2016 [Available from: https://www.bma.org.uk/advice/employment/gp-practices/service-provision/duty-of-care-to-patients-regarding-test-results.

[3]England N. Standards for the communication of patient diagnostic test results on discharge from hospital. London2016.

[4]Haig KM, Sutton S, Whittington J. SBAR: a shared mental model for improving communication between clinicians. Jt Comm J Qual Patient Saf. 2006;32(3):167-75.

SPOT DIAGNOSIS

Answers on the last page. Send us your pictures!

York Teaching Hospital NHS Foundation Trust

Patient Safety Conference

Friday 9 June 2017 York Racecourse

If you wish to submit an abstract the guidance, template and more information can be found at:
www.yorkhospitals.nhs.uk/psconference2017

To register a place on the conference please contact: Liz.Jackson@york.nhs.uk

Pharmacy

Calcium & Colecalciferol (Vitamin D) Preparations

There is a wide range of calcium and colecalciferol (Vitamin D) preparations available. The following aims to summarise the current products and formulary advice.

New Patients

Adcal D3 chewable tablets are the Trust's formulary choice and should be used when initiating calcium and colecalciferol supplements. The recommended dose of Adcal D3 chewable tablets is ONE tablet TWICE daily. Twice daily dosing improves absorption compared to once daily.

Patients admitted on other forms of calcium and colecalciferol (vitamin D)

The Trust Drug and Therapeutics committee have agreed that Adcal D3 chewable tablets can be substituted for the calcium and vitamin D preparations shown in the table below.

Preparation:	Recommended dose:	Calcium (mg) per tablet:	Colecalciferol (units) per tablet
Adcal D3 chew tablets (Trust's formulary choice)	One BD	600	400
Accrete D3 tablets	One BD	600	400
Adcal D3 dissolve effervescent tablets	One BD	600	400
Cacit D3 granules	Two sachets per day	500	440
Calceos chew tablets	One BD	500	400
Calcichew D3 forte chew tablets	One BD	500	400
Natecal D3 chew tablets	One BD	600	400

Preparations not equivalent to Adcal D3 chewable tablets

If the patient is on a preparation which is not equivalent to Adcal D3 chewable tablets (see table below) the preparation they are on can be sourced from pharmacy. Alternatively the prescription can be changed to Adcal D3 chewable tablets and the dose altered.

Preparation:	Recommended dose:	Calcium (mg) per tablet:	Colecalciferol (units) per tablet:	Action:
Adcal D3 caplets. **Note:** contains half the amount of calcium and colecalciferol	**Two** BD	300	200	Order from pharmacy
Calfovit D3 powder	One sachet at night	1200	800	Order from pharmacy
Calcichew D3 1000mg/800 units once daily chewable tablets	One OD	1000	800	Change to Adcal D3 one BD
Calcichew D3 capules. **Note:** contains half the amount of colecalciferol	One BD	500	200	Refer to pharmacy or prescriber for advice

N.B: when either calcium carbonate (e.g. Calcichew) or colecalciferol (vitamin D) are prescribed alone, Adcal D3 chewable tablets should not be used as a substitute.

Prescribe according to Trust formulary. Adcal D3 chewable tablet is first choice.

If you have any questions or comments please contact Annabel Bojkowski 771 2182 or email Annabel.Bojkowski@york.nhs.uk

Medicines Policy Group

The IGNAZ App – for junior doctors

The IGNAZ 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 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

Designing and Implementing Electronic Paediatric Advanced Warning

Improving recognition of deteriorating in children in hospital is the key driver for the RCPCH S.A.F.E. (Situational Awareness For Everyone) project. Electronic patient records present opportunities to improve patient safety through reducing errors in recording. We developed and implemented a paediatric electronic observation system with automatic calculation of Paediatric Advanced Warning Score (PAWS). It was anticipated that this would improve outcomes, through better observation recording and PAWS calculation, prompting appropriate escalation of deteriorating patients.

Adult electronic observation and scoring systems were already in use in our trust. Our system built on that, allowing automatic selection of the correct age parameters and calculation of the PAWS using inputted observations. It also included escalation prompts. Staff training on assessment, observation standards, recognition of sick children, and the electronic system preceded the introduction.

Anticipated outcomes of reduced unplanned transfers to PICU and mortality on the paediatric ward were considered to be difficult to evidence since these events are rare. Therefore, process measures were used to demonstrate improvement.

Data was collected pre-implementation, at 2 months and 7 months' post implementation.

Recording of observations, calculation of PAWS and escalation improved following the introduction of the electronic system. The correct age chart is now used for all patients. The correct PAWS are recorded 96% of the time now compared to 70% pre-implementation. (Of those requiring transfer to PICU this was 100% vs. 31%). Frequency of observations was only prescribed in 16% pre-implementation. Frequency is now automatically updated with 99% compliance after 2 months. Escalation of ward patients improved from 56% to 82%.

Recording of PAWS and escalation has improved following the introduction of the electronic system. Documentation of medical reviews requires improvement. There is on-going development of the electronic system e.g. recent addition of neuro-observations.

The electronic system has been primarily designed to reduce error, making it easy for staff to do the right thing. Early warning scores should be not used in isolation. Used in combination with other S.A.F.E strategies, such as improved team and parent communications, we hope to demonstrate an improvement in unplanned transfers to PICU and mortality.

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Sign up to Safety

Sign up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. It launched on 24 June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world.

At the heart of Sign up to Safety is the philosophy of **locally led, self-directed safety improvement**. The ethos is that everyone of us should feel that they have the power to make a difference by focusing on creating a **positive and strong safety culture**.

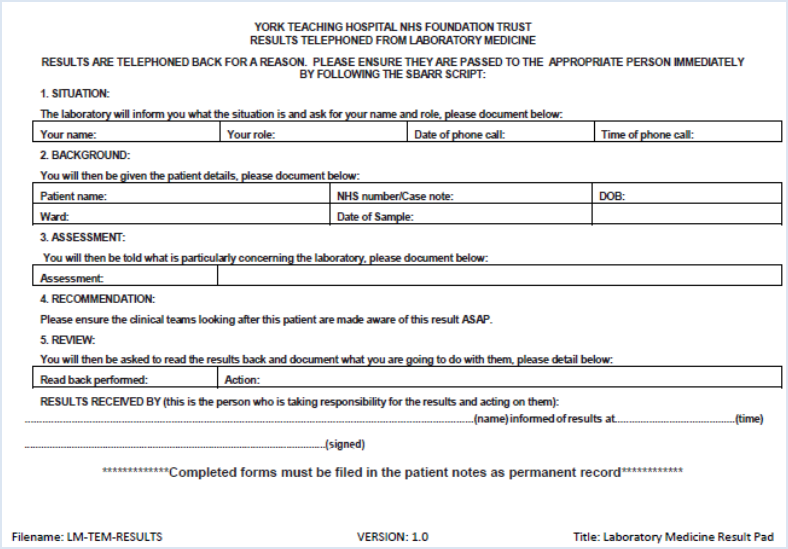
The campaign aims to support member organisations to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patient's safety, helping to ensure patients get harm free care every time, everywhere.

We should see each day and every action as an opportunity to learn and improve. We want our staff to feel that they have the power to make a difference; acknowledging that those who work closest to patients know best what needs to happen to reduce avoidable harm and save lives.

More information and resources are available from https://www.england.nhs.uk/signuptosafety/

Results telephoned from Laboratory Medicine

In response to previous concerns about timely and accurate notification to clinical staff of significantly abnormal results, an updated version of the results pad for results telephoned from Laboratory Medicine will shortly be distributed to the wards. It has been agreed by the Patient Safety Group that these forms, which follow the SBAR script (Situation Background Assessment Recommendation), will be the primary means of communicating this type of result. Laboratory staff will be following the read back procedures so that the risk of the wrong patient details being recorded are reduced.



YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
RESULTS TELEPHONED FROM LABORATORY MEDICINE

RESULTS ARE TELEPHONED BACK FOR A REASON. PLEASE ENSURE THEY ARE PASSED TO THE APPROPRIATE PERSON IMMEDIATELY BY FOLLOWING THE SBARR SCRIPT:

1. SITUATION:

The laboratory will inform you what the situation is and ask for your name and role, please document below:

Your name:	Your role:	Date of phone call:	Time of phone call:

2. BACKGROUND:

You will then be given the patient details, please document below:

Patient name:	NHS number/Case note:	DOB:
Ward:	Date of Sample:	

3. ASSESSMENT:

You will then be told what is particularly concerning the laboratory, please document below:

Assessment:	

4. RECOMMENDATION:

Please ensure the clinical teams looking after this patient are made aware of this result ASAP.

5. REVIEW:

You will then be asked to read the results back and document what you are going to do with them, please detail below:

Read back performed:	Action:

RESULTS RECEIVED BY (this is the person who is taking responsibility for the results and acting on them):

.....(name) informed of results at.....(time)

.....(signed)

**********Completed forms must be filed in the patient notes as permanent record**********

Filename: LM-TEM-RESULTS VERSION: 1.0 Title: Laboratory Medicine Result Pad

Results are telephoned directly to the ward or requestor because the patient may require prompt clinical assessment or treatment. It is therefore vital that these results are passed onto an appropriate person immediately. Whilst every effort is made for results to be released onto CPD in a timely fashion, the timescale may vary between pathology disciplines. Clinical staff should be able to work from the SBARR results sheet when making management decisions, confident that they are an accurate clinical record and can be relied upon to safely guide clinical management.

The SBAR results sheet is part of the patient's clinical record and must be filed in the patient's notes (or scanned and included in CPD).

As per the GMC Good Medical Practice guidance, it remains the responsibility of the requesting clinician to follow-up results and arrange appropriate action.

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Further information can be found in the Laboratory Medicine Policy available at:
https://www.yorkhospitals.nhs.uk/our_services/az_of_services/laboratory_medicine/laboratory_reports/

Spot Diagnosis - Answers

A. Ganglion cyst http://facultyofmedicine1.blogspot.co.uk/2011/01/what-is-your-medical-diagnosis-291.html B. Reynaud's phenomenon http://facultyofmedicine1.blogspot.co.uk/2011/01/what-is-your-medical-diagnosis-287.html c. Peripheral Cyanosis http://facultyofmedicine1.blogspot.co.uk/2010/12/what-is-your-medical-diagnosis-267.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)**
- **HIPCG (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 would like to get involved.

Editorial Team

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