Formerly Risky Business

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Sharing how we care

Learning from deaths

Many patients will experience excellent service from the NHS during their lifetime, however death may be an inevitable outcome following hours, days, months or years of care.

If mistakes happen or things could have been done better, we need to do more to understand why this occurred. Introduced in 2017, the National Guidance on Learning from Deaths describes key requirements to ensure we understand the causes of death in a patient and share the learning on why this occurred.

One of the minimum requirements was that each Trust should introduce a structured case record review process. The Trust has circa 2,000 adult inpatient deaths per year. Between April and July 2018, there have been 440 in hospital adult deaths. 162 (37%) have had a structured judgement review (SJR) undertaken. The key themes emerging from these reviews were:

- Delay in antibiotic administration for patients with sepsis
- Poor fluid balance monitoring
- Inappropriate reasons for DNACPR: e.g. Downs syndrome, learning difficulty, learning disability
- Lack of knowledge in recognising the dying chronically ill patient resulting in unnecessary interventions and treatment.
- Poor documentation of conversations with families when end of life is approaching
- Unnecessary hospital and ward transfers.

A new bereavement support information leaflet is currently being developed. It is essential that we learn from the feedback we get from bereaved families and carers. Losing a loved one can be an extremely traumatic event and the level of communication and support provided to families at this time can make a considerable difference. To this end, it is also essential that medical cause of death certificates are available as soon as possible and that referrals to the Coroner are completed in a timely manner. Both of these activities should be completed within three days of a patient passing. A referral to the Coroner when a cause is unknown can be completed by any Doctor. It doesn't have to be by a Doctor who has seen the patient alive.

The AMU and Respiratory Unit at Doncaster have a supply of death certificates which can be issued out of hours. Please seek guidance from your consultanty or medical registrar and always write your name and GMC number on the certificate.

Message of the month

Changes to NEWS2 and the SEPSIS IPOC - now available to order on Oracle. Key changes to NEWS2 are:

1. The columns on pages 2 and 3 have been reduced in number to enlarge the size of the boxes
2. There is specific reference to sepsis, sepsis screening using the sepsis IPOC and recording the outcome of any screening (Low risk-green, medium risk- amber, high risk – red)

Key changes to the SEPSIS IPOC are:

1. Reference to 'NEWS scores' and a red stripe at the outer page border to allow rapid location of the document
2. Please ensure a minimum of two sets of blood cultures when treating patients with sepsis.

Clinicians in training - we want you!

We have recently received fantastic feedback from our junior doctors, read about our recent **GMC survey results**. We value all of our clinicians in training and your contributions towards patient safety. If you would like to be part of this newsletter's editorial board, please get in touch with **Cindy.Storer@nhs.net**.

Marking World Sepsis Day

Sepsis has been identified as a key area to improve on recognition and early treatment for our patients at DBTH. On Thursday 13 September, we helped raised awareness of sepsis with our staff and visitors to try and reduce death from the illness.

Sepsis is an emergency and the number one most preventable death worldwide. Across the globe, 30 million people a year develop sepsis - nine million of them will die. Survivors may take many weeks or months to regain previous levels of function and quality of life – and some never regain it. Post-traumatic stress, loss of memory and significant mental health problems are common. In the UK 147,000 patients are admitted to hospital with sepsis each year, of which 44,000 will die – making it one of the most common causes of death in the country.

The annual costs of treating sepsis in the UK is estimated to be £10 billion. Over 70% of cases arise in the community. In Doncaster and Bassetlaw one third of patients admitted to critical care with life-threatening sepsis are from the Emergency Department, a further third are from assessment areas such as AMU, SAW and ATC, and the final third are from all other ward areas combined.

Improving chances of survival is dependent on the knowledge and skill of health professionals to screen for sepsis, recognise it and treat it urgently. NICE (National Institute for Health and Clinical Excellence) has produced an evidence-based guideline on recognition and management of sepsis. It advocates using NEWS2 to identify patients with potential sepsis and a structured screening tool to assess the severity of sepsis and risk of death. Both of these tools are available for staff to use at DBH. For more information about Sepsis at DBH contact lee.cutler@nhs.net.

Help save lives from Sepsis – use the tools at the top right.

Sepsis resources

- Follow this link to the website for World Sepsis Day
- Watch the three minute Sepsis video
- Take the Sepsis Quiz – to test your knowledge on sepsis

Antimicrobial Stewardship

Sepsis is treated with antibiotics, however, antibiotic resistance now poses a significant threat to the delivery of healthcare.

It is therefore imperative to ensure that principles of good antimicrobial stewardship and appropriate use of antibiotics are built into all activities, communication, training and actions relating to the treatment of sepsis.

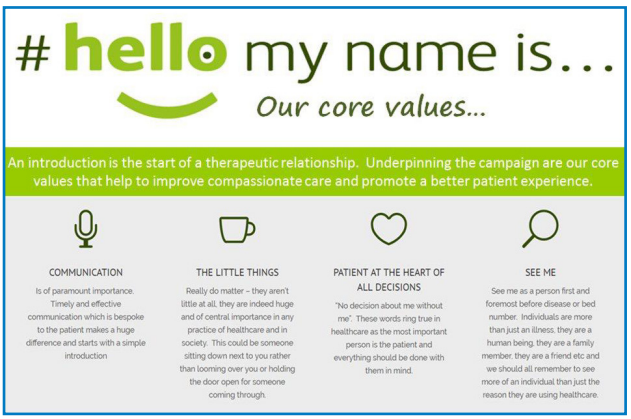
When treating sepsis, prompt antibiotic delivery, within an hour, based on local policy is important, along with a timely review to ensure the antibiotic is appropriate and a stop date has been indentified.

#HelloMyNameIs is five years old

Dr Kate Granger MBE was co-founder of the #hellomynameis campaign, a doctor and also a terminally ill cancer patient.

During a hospital stay in August 2013 with post-operative sepsis, she made the stark observation that many staff looking after her did not introduce themselves before delivering her care.

Kate felt it incredibly wrong that such a basic step in communication was missing. She decided to start a campaign, primarily using social media initially, to encourage and remind healthcare staff about the importance of introductions in healthcare. A national campaign, it is now five years old.



#HelloMyNameIs mug

Personalised with your name and drinks preferences, there's no more excuses now for not getting the right drink or right mug.

Perfect for when somebody else is making the drinks, they can simply refer to your drink preferences which are printed on both sides of the mug, ensuring you get the right drink and right mug every time. Mugs can be personalised with any name and any drinks preferences, or get creative and use lines two and three for other ideas, the choice is yours.

£1 Donated to Leeds Cares Charity formally known as Yorkshire Cancer Centre for every mug sold: https://tinyurl.com/dbthhmni Here is our team on St Leger, supporting #hellomynameis and encouraging staff to have a cuppa with patients who may be reluctant to drink while in hospital.

Please note: Speak with your line-manager if you are thinking about changing your name badge.


Mugging for the camera: The St Ledger team.

Patient **Safety**

Patient Safety Alerts are issued via the Central Alerting System (CAS), a web-based cascading system for issuing alerts.

Incidents are identified using a reporting system to spot emerging patterns at a national level, so that appropriate guidance can be developed and issued to protect patients from harm. Read about the Patient Safety Alert confirming removal or flushing of lines and cannulae after procedures: https://tinyurl.com/dbthalert

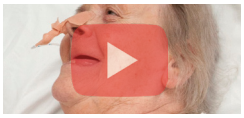
Patient Safety incidents are occurring from lapses in identifying and flushing all IV lines and cannulae at the end of a procedure when anaesthetic or intravenous sedative drugs have been given. If the IV lines and cannulae are not removed or effectively flushed residual anaesthetic and sedative drugs can later be inadvertently introduced into the patient's circulation causing muscle paralysis, unconsciousness and respiratory and cardiac arrest.

We have been asked to amend the Sign Out section of the WHO Checklist, or equivalent in local use, to include confirmation that before a patient leaves the procedural area cannulae and IV lines have been removed or flushed, and that this is documented.

Kathryn recalls her personal experience of temporary paralysis and respiratory arrest after residual anaesthetic drugs were not flushed from her lines and cannulae following surgery

Improving patient experience

When you look at a patient what do you see? The way they are now might not be representative of who they used to be.



Click here to read this month's poem, or watch it.

Delirium: What you should know

TIME AND SPACE

When patients develop delirium, this is due to complex interactions of multiple conditions and or risk factors. There is often a balance between risk factors and precipitating factors and this balance varies depending on the patients degree of vulnerability.

For example, an older person with dementia may only require a relatively minor event to become delirious, whereas in a young and usually fit person a major event, such as sepsis, would need to occur before that person developed delirium. The Yorkshire and Humber Delirium Clinical Network developed a useful acronym for recognising some risk factors and areas of concern when thinking about delirium TIME AND SPACE gives the staff guidance on what to consider if they have a patient who seems confused. It is also there to help prevent delirium, keeping on top of these risk factors can help reduce the risk of our patients becoming acutely confused.

The patients risk of delirium should be identified when the patient is clerked on admission and a plan of prevention should be started at this point. In elective patients, the risk of delirium should be identified and highlighted at pre-assessment. This will enable the patient and family to prepare for the possibility of delirium and to ensure staff are more aware on the wards. An audit was completed earlier this year looking at 72 patients admitted for surgery. Their admission notes were reviewed and of these 16 (22%) had symptoms of a possible delirium but only one had a recorded diagnosis of a possible delirium.

The length of stay for the patients with a possible delirium was almost two days longer than those without. Two extra days in hospital can lead to the patient becoming physically more de-conditioned, more likely to have a fall, pressure sores, other infections and overall go home less able than when they came in. It may be that if the delirium was recognised, treated, and in some cases prevented, that patient would have being discharged sooner and so be at much less risk. **For the poster click the image on the right.**

For more info regarding TIME AND SPACE, contact **Beth Cotton**, Lead Dementia Nurse (b.cotton@nhs.net)

Sharing how we care: Your health and wellbeing

We recognise that serious incidents can have a significant impact on staff who were involved or who may have witnessed the incident.

If you have been involved in a serious incident, like patients and families you will want to know what happened and why, and what can be done to prevent the incident happening again. At DBTH, Staff involved in the investigation process will have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. You will also be provided with information about the stages of the investigation and how you will be expected to contribute to the process. At DBTH we take staff Health and Wellbeing seriously and there are a variety of services available to support you. Click on the flower icon on the intranet (or above) to see what help and support is available.

Assisted partially sighted people

There are nearly two million blind or partially sighted people in the UK. People who are blind or partially sighted, or 'visually impaired' can be defined as having a sight defect which cannot be corrected by glasses alone.

You may notice some of our signs are in black with a yellow background. This is regarded as the clearest combination for someone with partial sight.

Patients with partial sight tell us it can be a challenge to navigate the carparks, avoiding moving cars and pedestrians to find the entrance and destination. If you notice someone struggling to find where they need to go, please consider offering to help to show patients the way. This sets the scene for the rest of their visit or stay.

In the outpatient setting, for partially sighted patients it may be helpful to assist them. If you call the patient's name, please wait for them to follow you. Don't disappear into the clinic as they may not see where you have gone.

Help with signing forms

Patients may not be able to see where to sign a form or see the cross marked to identify where to sign. It's better to highlight the area by blanking off using a black card.

Partially sighted patients may also appreciate if you identify where things are on their bedside table.

Sometime it is also helpful to explain where food is on the plate, using a clock face- for instance, the meat is at 3 o'clock.

Letters

All documents should be produced in clear print. The minimum point size for clear print is 14. The point size for large print is 16 to 22.

Fonts such as Arial, Helvetica and Futura are easier to read. Some clear serif fonts such as Baskerville or classic Garamond may be used for small sections where a different text is required.

As a general rule avoid using highly stylised typefaces. The use of handwriting requires felt tip pens, thicker lines and larger writing.

Avoid italics and the underlining of text. The type weight of headings should be bold or semi bold. In body copy, however, bold type and the use of italics should only be used sparingly, for emphasis, as it can be difficult to read in large amounts. Avoid upper casing. Capital letters give less variation and so are more difficult to read quickly. Titles Should Be Written In Both Upper And Lower Case.

Achieving: From Health Care Assistant to Star of the Year, we celebrate Curtis' journey click here.

This newsletter was developed by: Mandy Dalton, LFD lead, Dr Lee Cutler, Nurse Consultant Critical Care. Dr Ken Agwuh, Consultant Microbiologist, & Director of Infection Prevention and Control. Beth Cotton, Lead Dementia Nurse. Joanne Blockley, Complaints Manager. Cindy Storer, Deputy Director of Quality and Governance. Dr Tim Noble, Deputy Medical Director.

Protecting: Remember, flu can lead to sepsis, protect yourself, colleagues and patients click here.