NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Sharing how we care

We care

1st World Patient Safety Day 2019 (WPSD)

17 September

The World Health Organisation (WHO) have announced that 'Patient Safety: A global health priority' is its theme for the 2019 World Patient Safety Day (WPSD).

Read more about it here.

On 17 September 2019 we will be celebrating WPSD.

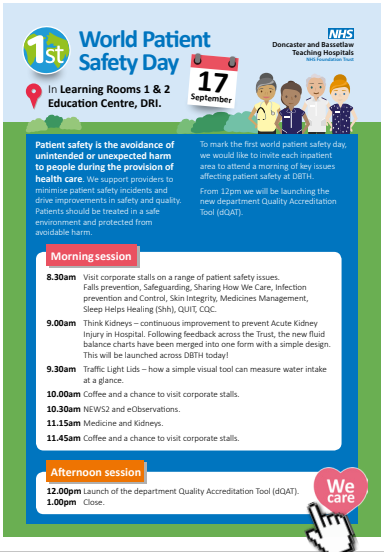
The morning's theme will be 'Think Kidneys.' We have listened to feedback around the two fluid balance charts currently in use and made changes. This means there will be one 24 hour chart with IV prescription on one side and a 24 hour fluid balance on the other in use across DBTH. This poster has been revised from the previous ones you may have seen and includes the new WPR number to order the new fluid balance charts WPR42323. After 17 September, please make sure all old fluid balance charts have been removed from your clinical area.

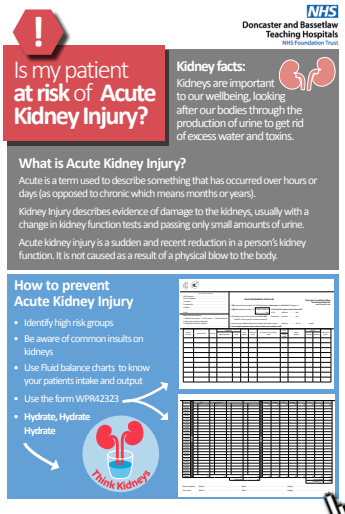
At 12.00, we are launching the new department Quality Accreditation Tool (dQAT). This will ensure that our department areas are working to the same clinical standards as our inpatient areas.

Please feel free to call and chat to the corporate staff holders. To book and attend, please contact Julie Scarborough julie.scarborough@nhs.net or Mary Fletcher mary.fletcher@nhs.net

Planning has now started for our third **Sharing How We Care Conference (SHWC2020).** This will be at the Hilton 2 April 2020. Please save the date.

We will keep you updated with the agenda and how to book nearer the time. For more information, please contact Mary Fletcher mary.fletcher@nhs.net





Print and display these posters in your clinical areas.

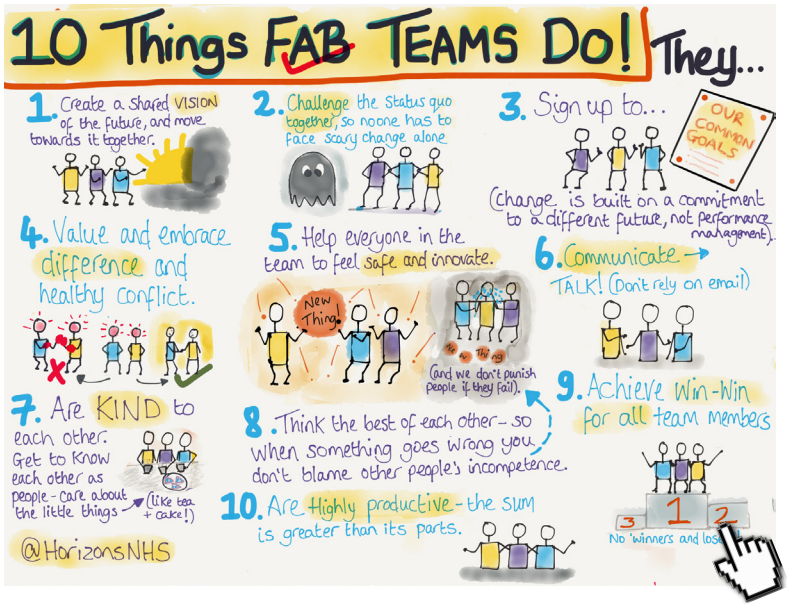
Safety Culture

Building a “safety culture” and embedding it is vital for improving patient safety and helping people work safely in all sectors of health and care. But what exactly is a safety culture? It’s a phrase often used yet seldom clearly explained.

> “Colleagues are your work family… You are allowed to love them and cherish them and to be as kind to them as they are to their patients.”
>
> Elin Roddy, Respiratory/Gen Med Consultant at The Shrewsbury and Telford Hospital NHS Trust

Culture is defined and measured in so many ways. Commonly it is defined as values, attitudes, norms, beliefs, and behaviours; “the way we do things round here” or “the way we behave when no one is looking”.

A common misconception is that there is ‘one culture’ in an organisation. In actual fact there are multiple. Cultures can be different from team to team and department to department. It may even be defined differently from one person to the next. It is in many ways intangible. But you can feel it, it sets the tone, and you know when it is supportive or toxic.



What can you do to build a positive culture?

Say thank you to the people around you, value and appreciate them, go out of your way to help people who need it. Develop relationships and friendships and spread the messages as you go along. People are desperate for hope and to a move away from the relentless negativity to a more positive interpretation of safety and you can do that for them.

Safety culture is explained in this three minute video:
https://vimeo.com/277108221

If you haven’t seen the infographic developed by Suzette Woodward from Sign Up to Safety yet, please print a copy and place it in your work area.

Message of the Month

Tetanus
Tetanus is a serious but rare condition caused by bacteria getting into a wound. Most people who get tetanus weren't vaccinated against it or didn't complete the entire vaccination schedule.

An older patient recently presented at DRI with symptoms including stiffness in the jaw muscles (lockjaw). She had a recent history of a gardening injury and had attended her GP surgery for the tetanus vaccine. Unfortunately the patient also needed an injection of tetanus immunoglobulin and this wasn't given at the time.

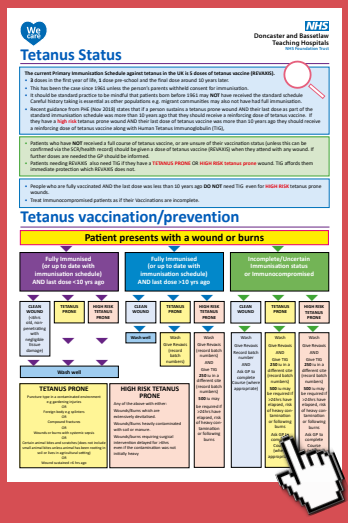
Tetanus immunoglobulin is a medication containing antibodies that kill the tetanus bacteria. It provides immediate but short term protection from tetanus. The patient did not recover from the delay in treatment and sadly died in our hospital.

What do I need to know about Tetanus?
A tetanus vaccination is given as part of the NHS childhood vaccination programme. This course of five injections should provide long-lasting protection against tetanus. However, if you or your child has a deep or dirty wound, it's best to get medical advice.

Are we improving communication between the Hospitals and GP surgeries?

A new tetanus flow chart has been developed to ensure there is learning from this incident and patients attending our emergency departments for Tetanus immunoglobulin are identified and have the medicine administered.

Print and display this poster to share the pathway in your area.



Sharing How We Care **after discharge**

Admission to critical care can have far-reaching psychological effects because of the distinct environment.

After critical care, patients may experience amnesia, continued hallucinations or flashbacks, anxiety, depression, and dreams and nightmares. Follow-up services can help patients come to terms with their experiences of critical illness and provide the opportunity to access further intervention if desired.

Patients and families on Department of Critical Care (DCC) experience various emotions throughout the patients' journey, from the point of admission to discharge. It may not be until after their stay in hospital that they want to understand and seek clarity to why they may have felt like this, what happened and why they still feel the way they do.

Staff on DCC wanted to provide this support and help patients and families come to terms with an admission to critical care. The DCC support group is a self- help group which happens on the first Wednesday of every month at the Community Centre in Armthorpe.

At the DCC support group, staff are there to support and guide patients in talking to each other and sharing their experiences in order to aid recovery. There are sometimes questions about the hospital stay that can be answered. The DCC team believe that it is important for these patients to speak to each other so they feel they are not alone in their recovery.


Department of Critical Care (DCC) Support Group

Stephanie Lee, Senior Physiotherapist told us, "Our patients have gained so much for attending the group being able to share similar experiences with each other and be able to listen to one another to what they have done to help manage these feelings. As our patients are still recovering we have been able to support them by arranging guest speakers to come to the group to be able to speak to the patients and answer any questions. These guest speakers have included; Dietitians, Physiotherapists, Counsellors. We need to keep spreading the word about support group. We can all do this when a patient is transferred to your ward from DCC. Take that moment to speak to these patients, give them the opportunity to talk about their feelings and emotions and let them know the support group is there if they wish to have more information about it".

For more information, please contact Stephanie Lee stephanie.holden3@nhs.net

Learning from Inquest and family complaint

The coroner holds an inquest if a death has been sudden and unexplained, when the cause is unknown, or the death is unnatural. This is usually held in a court, but can also be held in other public places.

The purpose of an inquest is to ascertain **who** the person was and to establish the following: **when, where and how they died.** Coroners increasingly use narrative conclusions, which set out a factual summary of what happened. These may include references to failings or omissions on the part of medical staff.

At a recent inquest, learning was identified to share with all Trust staff. A patient with a dislocated thumb and undiagnosed delirium was admitted to DRI and prescribed PRN (as and when) analgesia. He was unable to confirm he was in pain when assessed using routine pain scores by the clinical teams. As such, he didn't have regular pain relief. This caused distress to the patient as well as the family as his body language and facial expressions built into a picture of a person not being them self.

What can you do?

Hospitals are busy environments where the focus is on patients' physical care. However, improving pain management for patients who are unable to tell you they are in pain has been identified as a priority from the Alzheimer's Society (2009). The consistent use of a observational pain assessment tool such as the one adopted in our Trust may help achieve these improvements and reduce the need for enhanced care. Click here to access a pdf of the Trust's assessment tool.

In patients with cognitive impairment, it is important that staff are aware of the importance of detecting changes from normal behaviour that may indicate pain. Detecting changes in behaviour is difficult when usual behaviour is not known; involving someone close to the patient who has knowledge of their usual behaviour is recommended.

What else can you do?

We encourage all clinical staff to ensure there is a This is Me for patients to improve staff understanding of what the patient is like. Click here to access the form on The Hive.

Language of Frailty

Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication. Read more about frailty here.

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10 per cent of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85.

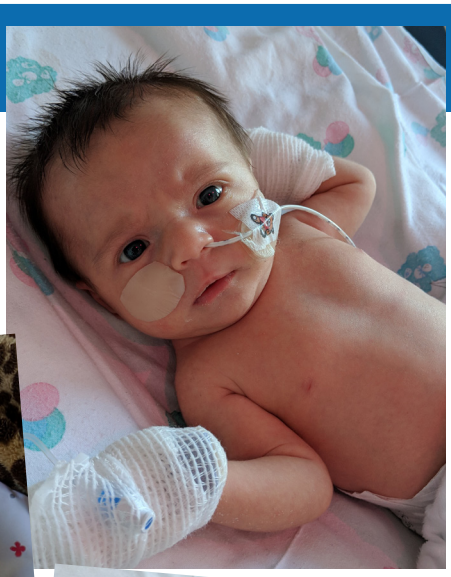
The language and management of frailty can act as barriers to engaging with older people (and their families) who may not perceive themselves, or wish to be defined, by a term that is often associated with increased vulnerability and dependency. Older people may not recognise themselves as living with frailty and there is evidence that older people do not want to be considered as 'frail,' although happy to accept that they are an older person.

Before and during the inquest, the family were distressed that the term 'frail' had been used to describe their loved one, without the clinical rational of the diagnosis.

It is important to remember and communicate with patients and families, that:

- Frailty varies in severity (individuals should not be labelled as being frail or not frail but simply that they have frailty).
- The frailty state for an individual is not static; it can be made better and worse.
- Frailty is not an inevitable part of ageing; it is a long term condition in the same sense that diabetes or Alzheimer's disease is.

Learning from **Prevention**



Palivizumab helps to protect vulnerable babies and infants with complex respiratory and cardiac conditions. These patients are at high risk of contracting Respiratory Syncytial Virus (RSV) which is likely to require admission to hospital or delay cardiac surgery.

A course of five immunisations are administered every 28 days over the RSV season (October to March). In 2017/18 at DRI of 26 eligible patients only 2 received the expected length of course. The immunisations were given on a busy acute admissions area which increased the risk of exposure to infections. There was no formal referral process and no system to monitor compliance.

In September 2018 the trust appointed two new Paediatric Respiratory Nurse Specialists (PRNS), Nadine Cooper and Emma James. With a clear need for change they developed a specialised nurse led clinic for patients who were eligible to receive Palivizumab. Nadine and Emma worked closely with members of the multidisciplinary team to develop a sustainable service. They identified a strong referral pathway, ensured there was a clear standard operating procedure and a process to audit the service.

The service was taken away from an acute area which reduced the risk of infection also the time in the hospital was decreased due to a reduction in the pre immunisation checks. The PRNS developed a system to monitor compliance and set up a reminder service for families to lessen the risk of missed appointments. The PRNS build up family centered relationships and were available as an identified point of contact for the families.

Changes to the service were a huge success and the nurse led Palivizumab clinic saw an extremely significant improvement. In 2018/19 at DRI all 31 patients identified as eligible received the expected length of course, this meant no delayed cardiac surgeries and patients with complex respiratory conditions were protected against the virus preventing possible hospital admissions.

Parent feedback:

"Our daughter Esmai-Grace had her Palivizumab injections since being diagnosed with cardiac problems at 4 weeks old.

Emma and Nadine visited us when Esmai was admitted to hospital and explained what it was, what it was for, and discussed how and when Esmai would need the vaccines in great detail. They answered all of our questions. We received appointments for the clinics and either Emma or Nadine phoned before each appointment to check Esmai was doing ok and remind us of the appointment.

Clinic was accessible and easy to find and on a couple of occasions when Esmai was poorly/admitted to hospital they arranged for her to have her jab up on the ward to make it even easier for us.

We we're given contact details for Nadine and Emma when we first met and were able to contact them with any questions or queries and they we're always helpful and answered or returned calls promptly.

We found both Nadine and Emma easy to talk to and super helpful and informative and they have both been FAB with Esmai making a tricky time a whole lot less stressful."

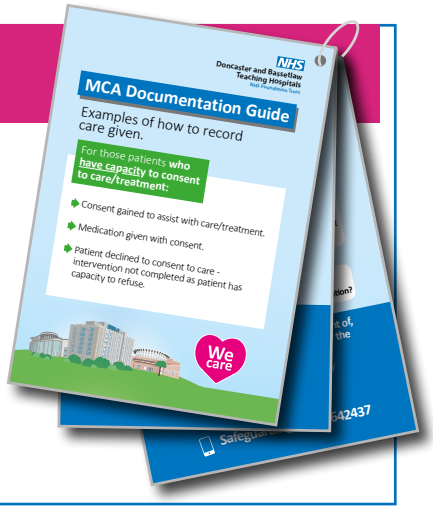
For more information, please contact Nadine Cooper, Respiratory Nurse Specialist nadine.cooper1@nhs.net

Mental Capacity Act

The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

If you make a decision for someone who doesn't have capacity, it must be in their best interests. Treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms.

If you are unsure about the principles of the MCA and what you should document in clinical notes, we have developed a handy pocket guide. The safeguarding team have a printed supply of these guides but you can also access the pdf here.



Trust-wide Delirium Audit

What is delirium?

Delirium is a common, serious but often treatable condition that starts suddenly in someone who is unwell. It causes a person to become easily distracted and more confused than normal. Delirium can be very distressing for the person and their family.

Nationally, 18-35% of patients in hospital experience delirium. This year we audited how many patients had been diagnosed with delirium when they were showing symptoms. The audit showed only 11.1% of patients with delirium had a formal diagnosis.

About the audit

- The audit took place on 3 separate days across this year.
- 559 patients were included across adult inpatient areas.
- The auditors were looking at current admission notes and the way clinicians describe changes to cognition and behaviour compared to how many times we consider a diagnosis of delirium.

Results

- 62 patients had a diagnosis of delirium written in their notes but...
- Another 95 patients had changes to their behaviour and cognition. Delirium did not appear to have been considered.
- Average length of stay is higher for people with delirium, particularly for those over the age of 65.
- By not recognising delirium in our patients, we then fail to adhere to NICE guidance in treating delirium.

Next steps

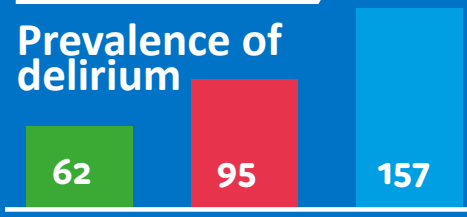
- Ensure all staff are accessing appropriate training and support such as the Person Centred Care training day and the Enhanced Care Collaborative.
- Offer bespoke training where needed.
- Share the Trust Delirium Guidelines and encourage the wide use of TIME AND SPACE for delirium risk factors.

Average length of stay (days)

10.32 delirium

8.85 no delirium

Prevalence of delirium



Remember **TIME AND SPACE**

		Do...	Don't...
T	Toilet	• Follow Delirium Guidelines.	• Change bed/ward.
I	Infection	• Re-orientate frequently.	• Argue/confront.
M	Medication	• Use calming speech. Involve family/friends.	• Catheterise – unless essential.
E	Electrolytes	• Walk to toilet frequently.	• Restrain – do allow to walk with supervision.
A	Anxiety/Depression	• Be kind, calm and mindful of emotional needs.	• Sedate unless part of treatment plan.
N	Nutrition/Hydration		
D	Disorientation		
S	Sleep		
P	Pain		
A	Alcohol/ Drugs		
C	Constipation		
E	Environment		

Key Takeaway Message

How do you diagnose delirium? Nationally, the 4AT is recommended, but there's another quick and easy tool:

SQiD (Single Question in Delirium)

> Ask family/carers "Do you think [patient] has been more confused lately?" If the answer is yes, then **think delirium!**

> If family or carers are not present **- think delirium**, until this is ruled out.

Visit the YHCN website for more resources for your area:
http://www.yhscn.nhs.uk/mental-health-clinic/Dementia/Delirium.php

Thanks this month go to: Cindy Storer, Hannah Stirland, Becky McCombe, Bonny Stevenson, Stephanie Lee, Nadine Cooper, Pat Johnson, Beth Cotton, Mary Fletcher and Maggie Gregory.