We care

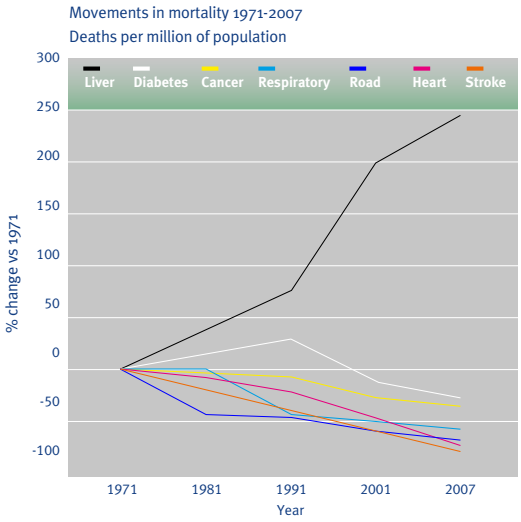
NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Sharing how we care

Learning from patients with Liver Disease

Liver disease is now the fifth most common cause of death in the UK. What was once thought to be a rare disease is emerging to be a major killer and its prevalence has risen significantly year on year in recent times (see the table, shown right, from the RCN competency framework for caring for people with liver disease).

Access the RCN Competence Framework here



There are three major reasons for this significant increase: alcohol, viral hepatitis and obesity leading to non-alcoholic fatty liver disease (NAFLD). These three areas are largely preventable causes and have been attributed to changes in lifestyle. Public attention surrounding liver disease is not always positive due to its links to health inequalities and also the stigmatisation of this disease being 'self-inflicted' but there is a lot we can do.

Age is no barrier to liver disease and as such, raising awareness of risk factors in the form of health education and promotion from an early age should be encouraged ie, obesity in children and safe limits for drinking alcohol in the older population.

This is an extremely important public health message as there is a great need to reverse the growing problem, we all need to promote a healthy liver as a way of life to the next generation.

What are we doing?

On 2 December 2019, colleagues in medicine held the first Trust Liver Study day. Over 60 people attended a packed day to learn more about caring for patients with liver disease. Attendees learnt that Doncaster has a higher rate of patients with liver disease than nationally and not all patients present early enough to be able to give advice that may prevent the liver deteriorating.

The take home message from Dr Jo Sayer was:

1. Liver disease is asymptomatic until the liver damage is irreversible. If patients have an abnormal liver blood test or abnormal liver on the ultrasound scan, don't ignore it because these are the patients where the liver damage can be corrected.

2. The 3 common causes of liver failure are treatable and preventable so:

- Take an alcohol history and give brief advice and guidance (this is also a CQUIN this year)
- Screen for viral hepatitis and HIV in all patients with risk factors. Make sure all patients are considered for hepatitis B vaccination, especially children
- Think about managing diabetes and obesity with advice on dietary intake and regular exercise.

Follow this link to a short video about the Liver Care Bundle and decompensated liver cirrhosis from the BSG. It is 15 minutes long but has been developed to support learning to improve care for patients with suspected liver cirrhosis.

This link provides more information on the liver care bundle. It is intended for acute medicine within the first 24 hours of arrival.

Learning from Patients presenting with Neck Pain

These have been 3 recent incidents of patients presenting with non-specific neck pain, which turned out to be a serious diagnosis. These were originally presented as a lunchtime lecture by Nikki Severein-Kirk, deputy head of patient safety on 20 September 2019.

Patient A

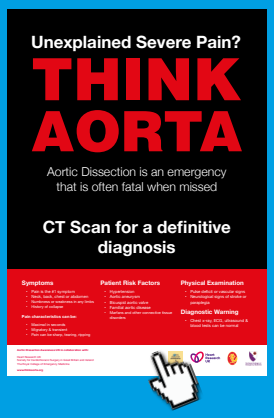
Patient A, 27 year old professional sportsman, with a known bicuspid aortic valve and a recent shoulder injury, presented in ED with sudden onset of left sided neck pain radiating to the shoulder, arm and chest. This was associated with feeling cold and clammy.

His blood tests were all within normal limits, chest assessed as clear, the ECG was normal sinus rhythm and the Troponin (cardiac specific) blood test was slightly raised. This was repeated a few hours later and there was no significant increase. Following a senior review he was discharged home and his General Practitioner was asked to arrange follow up with the chest pain clinic. He was advised to refrain from physical exertion until after he was reviewed in the clinic.

Four days later he had a sudden collapse and cardiac arrest from which he could not be resuscitated. The post mortem examination showed that he had a ruptured ascending thoracic aortic aneurysm.

What is the learning?

Aortic dissection is an emergency that
is often fatal when missed. The Royal College of emergency medicine has shared this alert to encourage clinicians looking after patients with unexplained severe pain to THINK AORTA.



Please print off and display this poster in your area

Please listen to the podcast initiated by the survivors and relatives of aortic dissection in the group Aortic Dissection Awareness UK.

Patient B

Patient B a 19 year old, attended the Emergency Department complaining of left shoulder pain radiating to the jaw. The initial observations were recorded and the NEWS 2 recorded as 4, this was repeated after 30 minutes and the NEWS 2 of 0. Following reassessment, the patient was discharged home, with the advice to re-attend if the pain returned. Two days later the patient re-presented to the Emergency Department with left sided chest pain, described as heaviness radiating to the left jaw and arm for a couple of days. On assessment a systolic murmur was heard, Troponin blood test was 9 and therefore admission to the Acute Medical Unit was arranged.

The following day an Echocardiogram showed severe aortic regurgitation and a dilated aortic root. There was reviewed by the Cardiologist and transfer to the Coronary care Unit (CCU). Subsequent referral to the cardiothoracic surgeons at Sheffield was made. Two days later, while on CCU, the patient suddenly deteriorated and a cardiac arrest with unsuccessful resuscitation. Following the death the post mortem examination showed a ruptured aortic aneurysm.

What is the learning?

The patient had been correctly diagnosed on the second presentation. Admission, monitoring and referral to a tertiary centre was appropriately arranged. Sadly there was an unexpected deterioration which no one could have predicted.

Patient C

Patient C, an 88 year old, attended the emergency department with symptoms of facial weakness, difficulties swallowing and drooping of the right eye and mouth. Multiple investigations were carried out, a stroke was ruled out. She was discharged home with follow-up arranged in the maxillo-facial clinic.

The following day Patient C re-presented with neck pain, difficulty swallowing and “lock jaw”. A 10 day old gardening wound on the shin was then noted and admission to the Acute Medical Unit for ongoing tests and investigations followed.

The following day she deteriorated and diagnosed with Tetanus from the leg wound. She was transferred to theatre to have her wound debrided and transferred to the Department of Critical Care where she was supported and treated with Immunoglobulins.

Although, she initially responded to treatment, one month after admission she deteriorated and died.

What is the learning?

A new Tetanus pathway across primary and secondary care has been developed for all health professionals to follow. This was originally shared in the September 2019 issue of this newsletter and **can be found here.**

Public Health England PHE have now developed a Tetanus quick guide poster, which is almost identical to the work developed by DBTH. **Dr Ken Agwuh has confirmed, the Trust protocol is the one DBTH staff should refer to for consideration of treating Tetanus**

Learning from Inquest

A recent Inquest discussed the case of a patient who presented to the ED after a fall at home. On arrival to ED, the patient was alert and communicating without any apparent issues. Handover between the initial attending solo paramedic to the double ambulance crew included a history of the patient sustaining a head injury and that they were on warfarin. Unfortunately, this information wasn't then handed over by the double ambulance crew to the teams in ED.

Whilst in the department, the patient began to suddenly deteriorate. At this point staff realised there was no result for PT/APTT as the sample had been reported as 'insufficient'. Repeat coagulation sample showed high INR with imaging indicating a cerebral bleed. Warfarin was reversed using Vitamin K but the patient was not seen as stable for transfer to Sheffield and end of life care was commenced.

What is the learning?

End of Life Care

The patient's wife informed us that she was taken to a different cubicle to wait while the patient was being triaged. By the time she was brought to sit with him, he had started to deteriorate, meaning she was left feeling she lost opportunity to be with him while he was conscious.

Patients and their families tell us that they would like to be asked if they want to be present with their loved one. While some families may choose to wait until their relative is seen, some may wish to stay. In the case of older patients, patients with LD, autism, dementia or communication difficulties, the families input is vital for a comprehensive history and their peace of mind. We only have one chance to get it right for patients at end of life.

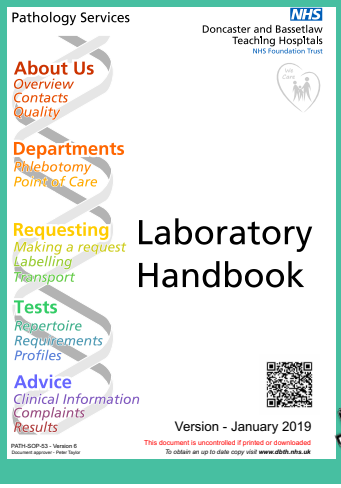
More information about end of life care can be found here.

Facts from the Laboratory

Around 10% of blood samples collected by clinical areas are not suitable for analysis; approximately half of these are sample quality issues and the other half wrong sample / labelling issues.

The Pathology services laboratory handbook is a helpful guide for more information.

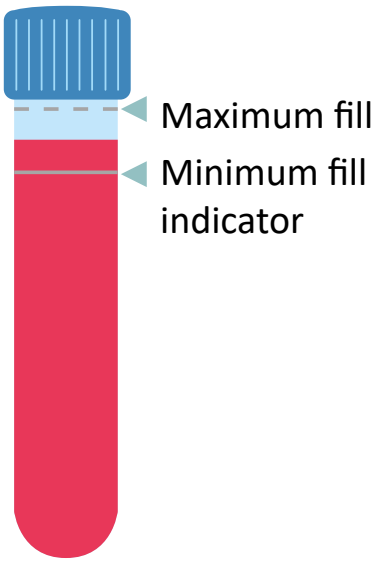
Access your copy here.



Learning Points

Please ensure that the correct samples, with the sufficient amount are sent to the laboratory for processing.

- Samples must not be under filled as this can cause falsely prolonged results
- Samples must not be over filled as this can cause over dilution with the citrate giving a falsely shortened result.
- Samples must be the **first blood sample taken**
- Samples should be mixed a minimum of 3-4 times to prevent clotting
- The picture here is a minimum fill line on the tube itself **(not the label)**



Learning from Pressure Ulcers

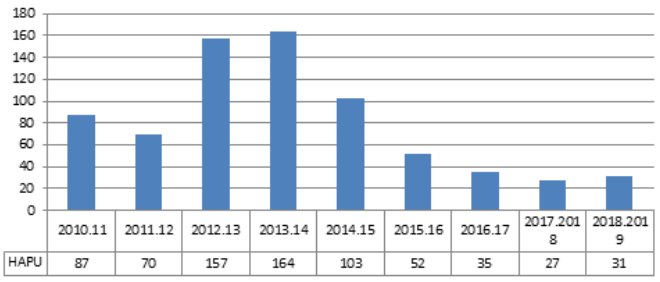
Pressure ulcers remain a challenge for the patients who develop them and the healthcare professionals involved in their prevention and management. Despite extensive prevention programmes, evidence suggests about 1,700 to 2,000 patients a month, in English hospitals, develop pressure ulcers.

How many serious pressure ulcers do our patients get?

At DBTH we have been recording the numbers patients with severe, avoidable, hospital acquired pressure ulcers (above category 2) since 2010/11.

The numbers of cases were at the highest in 2013/14 but have significantly improved during this time (see the graph below).

Patients with avoidable severe HAPU (above category 2)



	2010.11	2011.12	2012.13	2013.14	2014.15	2015.16	2016.17	2017.2018	2018.2019
HAPU	87	70	157	164	103	52	35	27	31

What has changed with the reporting?

In April 2019, NHS improvement (NHSi) changed the guidelines around reporting Hospital Acquired Pressure Ulcers and advised that using terms like avoidable and unavoidable are unhelpful in patient safety.

From April 2019, all pressure ulcers category 2 and above should have been reported to the national learning and reporting system (NRLS), via Datix web. These new guidelines meant we anticipate a rise in the reported numbers of all pressure ulcers above a category 2.

Dashboard and Datix

At DBTH, clinical staff were able to report all pressure ulcers and wounds via the internal dashboard system. This would trigger an email alert to the relevant teams and also refer the patient for a review by the Skin Integrity Team (SIT). Wards and departments would then have to complete an additional report onto Datix web for all pressure ulcer category 2 and above, which caused duplication and added workload.

During 2019 modifications within the Datix system have been made in order to amalgamate the Skin Integrity Dashboard and the Datix system. This enables the NRLS reporting to take place at the time of reporting pressure ulcers via the Skin Integrity dashboard. The pilot project has successfully been carried out with a phased Trust wide roll out to be completed by December 2019.

Many thanks to Mark Batley, Tracey Evans Phillips, Becky McCombe and Tracy Vernon for their hard work on this improvement.

Equipment

Pressure relieving equipment is a critical component to a successful pressure relieving strategy. During March/April 2019 Trust wide audits were undertaken to establish the condition of the pressure reducing static mattresses for the bed holding areas, pressure reducing trolley mattresses emergency departments and pressure reducing armchairs for the bed holding areas

The audit programme collated key information relating to the condition of the mattresses and chairs exploring the Infection control risk, patient safety risk and pressure ulcer risk.

Good News

The audit results helped to identify a significant number of static/trolley mattresses and chairs which needed replacing. After a successful business case, funding was agreed to replace the following this financial year:

226 Static (Foam) mattresses, 458 Chairs and 34 Trolley Mattresses

What about dynamic mattresses?

When patients need a dynamic (air or pressure relieving) mattress, Trust policy states that all patients either “at risk” of pressure ulcer development or who have an existing pressure ulcer should be nursed on a dynamic air mattresses within four hours of their risk occurring.

The Skin Integrity Team conducted a Trust wide audit of the patient’s pressure ulcer “at risk” profile during September 2019. The aim of the audit was to establish the patient risk profile versus the number of Dynamic air mattresses in use across the Trust. The audit results showed that 67% of patients had either a red or amber risk status highlighting that they were either “at risk” of pressure ulcer development or had an existing pressure ulcer.

In the month of October 2019, a total of 967 requests for dynamic air mattresses via the online ordering system were received. The medical technical services (MTS) were only able to meet 11% of these requests with an average response time of 9 days. This has resulted in clinical areas keeping pressure relieving mattresses and not returning them to MTS for servicing.

In an attempt to reduce the risk of patients developing a pressure ulcer, clinical staff are required to increase the turn and repositioning regime to every 2 hours when Dynamic Pressure relieving mattress are unavailable.

Learning from Pressure Ulcers

Turning patients every 2 hours, can then have a significant impact on patients sleep. We know that sleeps helps healing and want our patients to have as much sleep as possible.

You can download your information pack for the Shh campaign here.

What is happening next?

Work has now commenced with the estates team on an urgent business case for dynamic mattress replacement. We will keep you updated.

What is the learning from **Serious Incidents?**

The key themes from the hospital acquired pressure ulcers reported this year include:

Skin Inspections on admission

We know that a large number of patients come into our hospitals with a pressure ulcer present on admission (POA). This can sometimes be a safeguarding issue, meaning that a good quality skin inspection by a registered nurse is vital to ensure the appropriate next steps are taken.

Length of time on an ED Trolley.

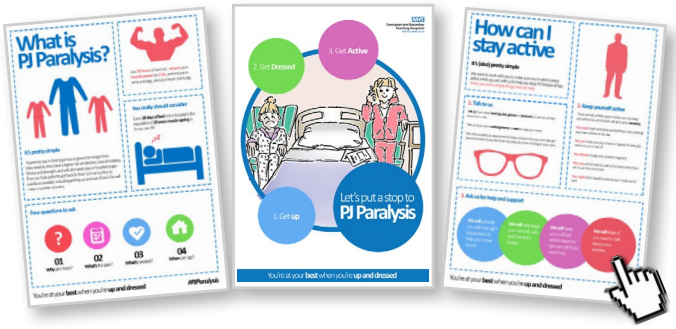
The Royal College of Emergency medicine issued a safety alert in April 2018, warning about the risks of pressure ulcers developing in older patients being left on an ED Trolley. **You can review the alert here.**

We have also adapted the EDFIT2SIT campaign to prevent patients from lying down on trolleys if they are well enough to sit up. **Click on the poster (left) to print your own copy.**

Early mobilisation and endPJparalysis.

There good evidence that encouraging patients to get dressed in the day and mobilise as much as possible during their hospital admission can reduce the risk of pressure ulcers (as well as deconditioning, leading to falls). We shared the resources and work we are doing to endPJparalysis in the June 2019 newsletter.

Click here to see the June edition.



Nutrition

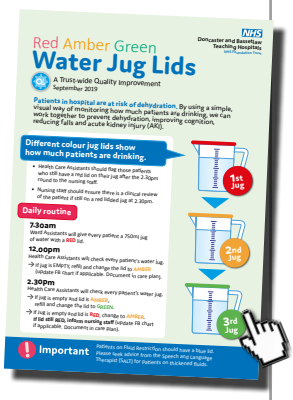
We know that good nutrition and hydration are a key element of good care. In January last year, we ended the protected mealtime's policy and adopted Making Mealtimes Matter (MMM). This means that staff patients and visitors (if they wish to help) should all be prepared for meal service. Read about MMM by clicking on the poster.

Hydration

Encouraging everyone who comes into contact with a patient to start that interaction with a drink was launched in November 2019. This simple initiative reminds everyone to support patients to drink more.

Water Jug Lids

The new water jug lid system was introduced in November 2019 as a simple visual tool to highlight how much water patients have drunk. Early evaluation has demonstrated that it is a challenge to get patients onto a green lid and all staff are much more aware that patients need help and encouragement to drink water to stay hydrated every day. Read more by clicking on the poster.



More information on the work of the skin integrity team is available on the Hive.

To contact the Lead Nurse for Skin Integrity Team contact Tracy.vernon@nhs.net

For more information on the Stop the Pressure campaign click here: https://nhs.stopthepressure.co.uk/

Learning from a Never Event in another Trust

Colleagues in Sheffield have reported a never event after a patient was administered insulin by a nurse, which had been drawn up in a syringe, from the patient's own insulin pen.

Insulin must NEVER be drawn out of a pen device.

When patients have been issued with an insulin pen, it is important that the pen is used. By using a syringe, the patients' insulin dose changed and they received an overdose. Although no harm occurred to the patient, the nurse who gave the insulin this way was unaware of the risks.

Learning from Compliments

The following compliments were posted on NHS Choices website in November 2019

Diabetic Resource Centre is first rate!

I've had T1 diabetes for almost 22 years and went to Bassetlaw when I was diagnosed. Unfortunately, I had to change hospitals as I moved away and had a number of bad experiences. However, when I moved back to the local area 18 years later, I was able to come back (and was pleased to find that my original DSN was still there!) Having now had my diabetes care under a number of different hospitals and GPs, I can honestly say that none of them come close to Bassetlaw. Here they get to know you and genuinely care. I always feel that they are doing their best to get me on the best treatment they can and they are extremely supportive.

End of life care

A close family member was admitted to ward C1 for end of life care. The care given by the nursing team was excellent, the stand out thing however was the side room we were given . It was very spacious and allowed many family members to spend time and also to stay overnight with our close relative. We are very grateful for the chance we were given at that time to be with our relative and that we did not cause disruption to other patients on the ward. Thank you.

Ophthalmology department

I had an appointment at the ophthalmology dept. Whist the appointment was approximately half an hour late in starting I was impressed by the quality of service thereafter. The junior doctor who carried out the initial examination was competent and willingly answered my questions. The subsequent examination by the consultant confirmed his diagnosis and again the consultant discussed his findings in lay mans language leaving me feeling confident of the diagnosis.. All in all I was extremely impressed by the service. I also found all the staff to be cheerful and helpful.

Thanks this month go to:
Cindy Storer, Tim Noble, Nikki Severein-Kirk, Miriam Boyack, Joanne Sayles, Jo Sayer, Joanne Pickersgill, Anurag Agrawal, Vimla Christopher, Tracy Vernon, Gemma Harte, Bonny Stevenson.