

VTE. ASSESS. PREVENT.

Venous Thromboembolism

VTE is the leading preventable cause of hospital deaths, ahead of pneumonia and infections.

Patients being cared for by us are still being harmed by, and several have died as a result of preventable blood clots.

This is because we

- Don't always complete an assessment when we should do
- Don't always act on the results of that assessment as we should.

ASSESS. PREVENT. EVERYTIME

Every patient has a right to know if they are at risk of developing a VTE.

All patients (who are not excluded) should have an assessment of their risk completed as soon as they are admitted to hospital.

Their risk should be re-assessed after they have been an inpatient for 24 hours and if their condition changes.

All patients should have the outcome of their assessment explained to them and the preventative measures planned.

The effectiveness of the preventative measures planned should be monitored and reviewed regularly.



Documenting assessment and prevention is easy on our EPR and we should check every day that it has been done.

Learning Matters: Thickening agents –near misses

Thickening agents

We have had two near miss incidents this week where thickening agents have been decanted into a non labelled pot and left within reach of patients.

In February 2015 the National Patient Safety Agency published an alert regarding '*Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder*' as a result of an incident where a care home resident died following the accidental ingestion of the thickening powder that had been left within their reach. The powder formed a solid mass and caused fatal airway obstruction.

What you need to know

- The qualified nurse responsible for the care of an individual patient requiring thickened fluids should risk assess each patient to decide identify storage for the agents.
- Thickening products should be stored out of reach of patients but still be visible to ensure they are used as required.
- Thickening agents **MUST NOT** be decanted into other pots i.e. cups, white medicine pots.
- Where the patient is or others in the vicinity are confused and/ or wandering alternative arrangements may need to ensure safe storage.
- On discharge, if the patient requires thickening agents safe storage and risks should be discussed with patients and/or carers.
- All near misses should be reported on Datix.

Learning Matters: Mortality



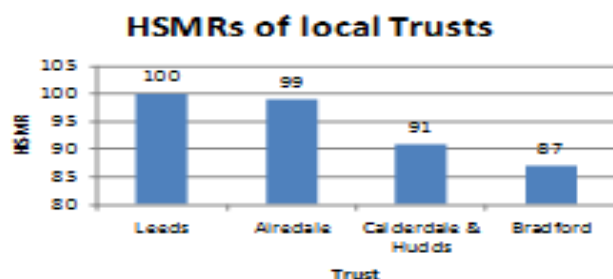
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Mortality statistics

HSMR (Hospital Standardised Mortality Ratio) is a measure of hospital inpatient mortality which shows whether the number of deaths is higher or lower than would be expected. The average score is 100, with lower scores being better than higher.

The Trust continues to have the lowest HSMR in the region, currently 86, which represents 167 less deaths than expected over the period September 2016 to August 2017. This reflects the high level of care we give.

Lower is better

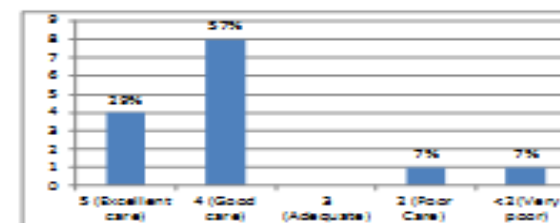


Findings from case notes reviews

All departments should be carrying out mortality reviews on patients using the Structured Judgement Review (SJR) method.

5% of deaths have been reviewed between July—Sept 2017 (we aim to get 25% of deaths reviewed). **86% of care reviewed was rated as good or excellent!**

Overall Assessment of Care Scores (includes all reviews)



Key themes identified:

- Good recognition of the sick patient;
- Excellent communication with patients and relatives;
- Initial care within the first 24 hrs seems to be very good with good evidence of implementing relevant treatments on time;
- Good multidisciplinary cooperation;
- Good use of palliative care.
- Second review highlighted:
- Several delays led to poor care in some aspects of treatment;
- Some evidence of poor documentation—lack of times recorded by clinician and some nursing notes only written briefly and in retrospect;
- Patient with suspected infectious disease admitted to an open ICU bed. The pathology report took several hours to be seen by medical staff, hence appropriate medication was slightly delayed (it is unlikely this influenced the outcome).

The poor/very poor care scores relate to an individual case which was subjected to a second review, as per protocol.

2017-18

For more information or to see the full reports, please contact Caroline Hanson, Quality & Patient Safety Facilitator, or Dr Harry Ashurst.



LEARNING MATTERS

McKinley T34 Syringe Driver incidents

Recent incidents and themes

A palliative patient was in pain and distressed, PRN medication was given and the patient settled. A syringe driver was prescribed to optimise symptom management but was not commenced for 6 hours and so the patient was again in severe pain. This distressed both the patient and his family. The reason for delay was staff were unsure how to set up the syringe driver and were waiting for a staff member with experience to start a shift. The syringe driver should have been commenced within 2 hours of prescribing as per McKinley T34 Syringe Driver Policy.

Several patients have been discharged home with the syringe driver locked box insitu. The District Nurse (DN) is then unable to access the syringe and so cannot reprime the syringe driver. This causes a delay in patients receiving essential treatment.

A dying patient was discharged home with a syringe driver insitu but the medication was not prescribed on the community prescription chart. The DN was unable to reprime the syringe driver and the GP was then required to prescribe the medication. This caused unnecessary delay for the patient in receiving vital medication.

A patient was converted from oral to subcutaneous opioid via a syringe driver. The oral dose was not discontinued resulting in an opioid overdose.

A dying patient was discharged home with a syringe driver insitu with the incorrect dose of medication prescribed on the community prescription chart. The patient is at risk of receiving an incorrect dose of medication and the delay in repriming the syringe driver resulted in poor symptom management.

What should we do?

All Registered General Nurses MUST:

- Complete the McKinley T34 Syringe Driver e-learning programme.
- Complete ward based competency assessment annually. Documents are available on the intranet (Palliative Care, McKinley T34 Syringe Pump, Section 4, Education Training)
- Seek help if needed when setting up a syringe driver*
- Remove locked box from **ALL** syringe drivers prior to discharge
- Ensure **ALL** syringe driver prescriptions & anticipatory medications are prescribed on the correct community prescription chart prior to discharge
- Check all prescriptions are for the right patient, right dose, right drug, right route and right time.



*How to get advice and support

Syringe Drivers must be commenced within 2 hours of prescribing. If you need support or guidance to set up a pump please go to the [Palliative Care Webpage](#) on the intranet or call the Palliative Care team on ext 4035 (Mon – Fri, 07.00 – 17.50)



Out of hours advice can be obtained via Marie Curie Hospice on 01274 337000



Quarter 4: 'Matters' rebranded by the Learning and Surveillance Hub


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