Making health and care systems fit for an ageing population—what do we need to do next?

By Professor David Oliver
President Elect of the British Geriatrics Society & Visiting Fellow at The Kings Fund

I have spent my NHS career as a hospital doctor specialising in geriatric medicine and I have led services within two trusts and taken on national leadership roles. In 2013, I became a Kings Fund Fellow alongside my NHS work. I go into many hospitals and health economies to advise on services, or to learn from local innovations. This has given me a great insight into the ‘state of play’ in services for older people and a platform to spread the message about high quality care to those not working directly in geriatric medicine. As part of my Kings Fund work, I led the writing of an ‘everything I have learned in one place’ paper ‘Making health and care systems fit for an ageing population’ (www.kingsfund.org.uk/events/making-health-and-care-services-fit-ageing-population) which is a practical resource aimed at those leading frontline services. It was accompanied by the 18th June conference, ‘Delivering innovations in the care of older people’, which allowed organisations from around the UK to speak about their own services and learn from others.

When the NHS was founded, 48% of people died before they reached 65. Now its only 14%, with the fastest growing group in society being those over 80. By 2030, a 65 year old man in England will live on average to 88 and a woman to 91. This represents a victory for society and a success for modern healthcare. We certainly shouldn’t use catastrophic language about the ‘ticking time bomb’ or ‘burden’ or ‘grey tsunami’ of ageing. Most older people self report their health as ‘good’ or ‘very good’ and people in their seventies and eighties report the highest levels of happiness of any group. If anything, older people are becoming healthier than those in previous generations. However, ageing will alter the very nature of health and healthcare for good.

There are now more people living not with one, but with multiple long term medical conditions, often in turn requiring multiple medications. Dementia already affects around 800,000 people in the UK and is set to double over the next two decades. Around 6% of the population over 65 live with a degree of frailty. There is a growing recognition that people with frailty have specific needs. They often present to health and care services with falls, confusion, loss of mobility or with non-specific failure to cope. Many older people report problems with mobility and often lose mobility rapidly in the face of acute illness, creating the need for adequate post-acute rehabilitation. Older people are the most likely to call 999, to be conveyed to hospital and to be admitted. It is also older people who are most likely to rely on support from carers and who are most likely to use multiple services and see multiple professionals’ and so suffer from disjointed and poorly co-ordinated care. Of course, most people requiring support at the end of life are older, making it essential to give them fair access to advance planning and palliative care support as well as choice towards the end of life.
Under the spotlight…

Does a person have capacity?

For a person to have capacity they must be able to:

1. Understand the information that is presented
2. Retain the information long enough to make the decision
3. Weigh up the information to make the decision
4. Communicate their decision by any means possible

Footnote:

Comment

Dr Des Holden
Medical Director

As an executive team we have not done enough in explaining what happens when people raise concerns and we have more to do in explaining what actions we take when things go wrong. To help with this, we are going to publish some of the patient stories raised through incidents or complaints and I would like you to read them and think about the lessons we take from them.

We have been told that we are within touching distance of being an outstanding organisation. What will get us there, is choosing to do the right thing in the moment when the choice matters, but it answering a call bell at the end of a shift, re-writing a drug chart that is unclear, or pointing out a problem no one else has recognised or dealt with. This will make us safer, effective and outstanding.

The Kings Fund Paper sets out the right skills, training and values.

The Mental Capacity Act 2005 protects individuals who are unable to make decisions for themselves and applies to all people over the age of 16 in England and Wales. It covers important decisions relating to an individual’s property, financial affairs and health and social care and also applies to everyday decisions, such as personal care, what to wear and what to eat. The five main principles of the Act must be followed by anyone supporting or making decisions on behalf of someone who may lack mental capacity. (For further information visit: http://intranet.sash.nhs.uk/department-directory/clinical-support/adult-safeguarding/deprivation-of-liberty-safeguards(dols)/)

Informed consent: barriers and holistic care

Informed consent for treatment and side effects is an ethical imperative and as a healthcare professional, it is important to be perceptive to common psychosocial barriers that may impact a patient’s ability to make an informed decision. There is a risk associated with providing large amounts of information at one point in time, or overloading a patient with information at a point in their treatment trajectory when they may be feeling afraid, confused or overwhelmed. We have a professional duty to act as patient advocate and exercise autonomy to ensure that the patient is well-informed. Barriers in understanding language, cultural, health beliefs and behaviours and age need to be considered; some elderly patients may be accustomed to the old paternalistic system of ‘doctor knows best’ and may not feel it is appropriate to question. What one clinician may determine ‘best’ in terms of treatment, may not necessarily align with the holistic needs of a patient. Being able to distinguish and anticipate an individual’s holistic needs is paramount. Building a relationship with the patient and getting to know them as an individual, allows us as practitioners to explain heart failure in a way that may appear unwise without lacking capacity. If a person lacks capacity, any decisions must be taken in their best interests, informed by seeking information from their next of kin, friends, family, nursing home staff, or an IMCA. If a person lacks capacity, the least restrictive option to their rights and freedoms should be taken.

‘Mental capacity’ is situation specific and if a person is deemed not to have capacity with regards to one situation at a given point in time, it does not mean they may necessarily lack capacity in the future.

By Dr Katy Davies
Consultant Geriatrician

We need a radical shift in the way care, coordination and support is based on prevention and wellbeing, proactive care and good post discharge support.

We need to ensure that when older people ageing through to end of life care, with nine key headings, from healthy active evidence for how we need to change under right skills, training and values.

The Journal Summer 2014

Thejournal@sash.nhs.uk

The Journal Summer 2014
Patent-centred care

FOCUS ON END OF LIFE CARE

By Dr Naomi Collins
Consultant in Palliative Care

This has been quite a year for end of life care. July 2013 saw the publication of Baroness Neuberger's independent review of the Liverpool Care Pathway (LCP) for the Department of Health. Whilst the report acknowledged that the LCP, if used correctly, could contribute to a person achieving a peaceful and dignified death, it also heard of too many instances in which the LCP was used with inadequate communication, approached as a 'tick box exercise' or perceived by the public as a conveyor belt to death. It therefore recommended that the LCP be phased out over 6-12 months and replaced by individualised care plans.

At SASH, the LCP was discontinued immediately and interim guidance issued. In March 2014 the new End of Life Care (EOLC) Plan, based on a document from Kingston NHS Foundation Trust, was launched throughout the hospital. The plan aims to provide prompts for medical and nursing staff of all the issues that have to be addressed in order to provide high quality, patient focussed care at the end of life.

The 4th National Audit of Care of the Dying Patient in Hospitals reported in May 2014 with a mixed picture at SASH. In some aspects of the organisational audit we did well, such as having taken part in a survey of bereaved relatives within the last two years (achieved by only 34% of hospitals). The report highlighted areas to focus on including initiating a weekend face to face service for palliative care; expanding the education programme for all staff on end of life care; providing quiet rooms for relatives and having a named board member with responsibility for end of life care. The latter issue has already been addressed, and the introduction of a six day palliative care service (with a view to moving to a seven day service) is planned for autumn 2014. The majority of other hospitals (at least 60%) are also currently not achieving these four areas. Of more concern, was the clinical audit based on a review of 49 sets of case notes of patients who died in SASH during May 2013. SASH performed below the national average for the ten aspects examined. This is obviously disappointing and requires urgent attention. It is worth remembering the audit is of documentation and not necessarily the care given, though everyone in healthcare knows if it is not documented, it is not evidenced that it is done. Removal of the LCP and introduction of the EOLC plan have, of course, occurred since May last year and it remains yet to be seen whether the new plan leads to an improvement in care at the end of life.

“The EOLC plan aims to provide prompts ... for all the issues that have been addressed”

“The responsiveness of EOLC at SASH has been found to be ‘outstanding’ by the CQC”

In the meantime, we are delighted to announce the planned development of a joint discharge liaison service between SASH and Marie Curie Cancer Care with the aim of improving the hospital discharge experience of patients approaching the end of life (whether they have cancer or not). This seven day a week service will consist of a trained nurse based in the hospital and two nursing assistants who will be available to provide hands on care at the patient’s home. We hope this will continue to enhance the responsiveness of EOLC at SASH, which has been found to be ‘outstanding’ by the CQC during their inspection earlier this summer.

Care continues even after death

By Liz Berry
Operational Manager for Cellular Pathology

When a patient dies, the responsibility and care for that patient continues until they are transferred into the care of a funeral director. Doctors have a professional responsibility to complete either the medical certificate of cause of death (MCCD), or a coroner’s referral, as soon as possible, especially as a decision from the coroner’s office can take two or three days. The MCCD and the cremation papers are normally prepared by junior doctors on behalf of the consultant who is ultimately responsible. Doctors should be mindful when completing these forms that the Registrar or the Medical Referee at the crematorium, has the power to reject a MCCD or a cremation, causing distress to the next of kin.

At this emotional time we need to be mindful of how our actions can be interpreted by the bereaved. The majority of our families want to finalise the funeral arrangements as soon as possible. However, only when they have received the MCCD from us can the family make an appointment with the registrar’s office to register the death. It is during the appointment with the registrar that the family receives the death certificate and other associated paperwork necessary to complete the funeral arrangements. It can become very frustrating and distressing for the family if they are unable to proceed with confirming funeral arrangements.

Bereavement officers often have the difficult task of explaining to the family why their loved one’s certificate is not ready, especially on a Tuesday if they died on Friday – to the family this has been four days. Rightly or wrongly, deaths should be registered in five calendar days which is why the family can become very anxious. From the families perspective, if it takes several days to complete, it can give the impression that we no longer care. Patient care is continuous and death is no barrier to this care. It is important that we demonstrate dignity, respect and compassion and do all we can to help make what is a very difficult time for family and loved ones a little easier to bear.

PRODUCING A ‘GOOD’ DEATH CERTIFICATE

By Ali Alhakim
Consultant Pathologist

When a patient dies and provided that there is no need for a coroners referral, (eg. accident, suicide, suspicious death, violence, neglect, industrial disease, unknown cause of death, during an operation/ultragenic death) then it is the statutory duty of the doctor who has attended the last illness to issue the MCCD.

‘Attended’ generally meaning a doctor who has cared for the patient during the illness that led to death. It is ultimately the responsibility of the consultant in charge of the patient’s care to ensure that the death is properly certified.

Doctors are expected to state the cause of death to the best of their knowledge and belief. The MCCD is set out in two parts – the immediate direct cause of death is stated in (Ia) and other conditions are stated in sequence in (Ib) and (Ic) so that (Ia) leads to (Ib) and (Ib) leads to (Ic). Other conditions that led to death (contributed but not related to 1a, 1b, or 1c) are entered in (II), but in this part, it must not be used to include any past medical history.

Footnote:
Junior doctor poster event

By Natalie Powell
Consultant Physician

In the first 30 years of the Trust there was an increase in the number of patients referred to the ICU and the need for basic life support skills became more apparent. The Trust recognised the importance of having a well-trained medical and nursing team to ensure patient safety. However, there was a lack of evidence to support the effectiveness of the training. The aim of this audit was to assess the percentage of junior doctors and nurses who were competent in basic life support skills.

There were three categories of junior doctors:

- Junior doctors who had completed basic life support training
- Junior doctors who had not completed basic life support training
- Junior doctors who had not completed basic life support training but had participated in the audit

The questionnaire was completed during a set time frame. Outcome measure: The percentage of junior doctors and nurses who were competent in basic life support skills.

Results:

- 49% of junior doctors and nurses were competent in basic life support skills.
- 90% of junior doctors and nurses who had completed basic life support training were competent.
- 80% of junior doctors and nurses who had not completed basic life support training but had participated in the audit were competent.

Conclusions:

- The audit highlighted the importance of basic life support training for junior doctors and nurses.
- It also identified areas for improvement in the training program.

References:

- American Heart Association. Basic life support for healthcare providers. Available from: http://circ.ahajournals.org/content/124/8/1386

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# Swallowing and Dysphagia: An Update

By Dr. Carine Mootoo
Consultant Physician

Dysphagia is a common problem in elderly patients and in those with neurological conditions. It is important to assess and manage swallowing problems to prevent aspiration and pneumonia. The use of a Swallowing Assessment Checklist can help assess and monitor swallowing function.

References:


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# An audit of Basic Life Support skills in Primary Care - need for refresher sessions

Dr. Amanda Mootoo
Consultant Physician

The audit aimed to assess the percentage of junior doctors who were competent in basic life support skills. The results indicated that 49% of junior doctors were competent, but the majority required refresher sessions.

References:

- American Heart Association. Basic life support for healthcare providers. Available from: http://circ.ahajournals.org/content/124/8/1386

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# Does a surgical port take-wood checklist improve documentation?

By Dr. Komal Chadha
Consultant Physician

The use of a checklist can improve documentation in surgical cases. The audit evaluated the impact of a checklist on documentation quality and found that it improved documentation in 50% of cases.

References:


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# Electronic Prescribing (ePrescribing) - By Dr. Oliver Redfern

By Dr. Oliver Redfern
Consultant Physician

Over the past year, a new system for electronic prescribing (ePrescribing) has been designed and implemented at the Trust. The system aims to improve the safety and efficiency of prescribing by reducing errors and streamlining the process. The audit evaluated the impact of ePrescribing on prescription errors and found a significant reduction in errors.

References:

- BMJ Quality & Safety. Electronic prescribing: a systematic review. Available from: http://qualitysafety.bmj.com/content/6/2/78
Clinical effectiveness
Audit
Research & development
Education & training

National Emergency Laparotomy Audit

By Mr Andrew Day
Senior Spk Surgery

and Mr Tim Campbell-Smith
Consultant Surgeon

The National Emergency Laparotomy Audit (NELA) began in December 2012, commissioned by the Healthcare Quality Improvement Partnership and is funded by NHS England. All NHS trusts are required to enter data to the audit. There are approximately 30,000 laparotomies performed per year in England and Wales, typically on patients who are very sick and elderly. The Emergency Laparotomy Network (founded in 2010) has identified that this cohort of patients can have a mortality rate of approximately 15% and in those patients aged over 80 it approaches 25%.

The aim of the audit is to drive quality improvement in the care of these patients and hopefully reduce the high rate of mortality and complications associated with emergency laparotomies. All patients that require an emergency laparotomy must be identified on their admission with assessment by a senior surgeon. Prompt resuscitation with intravenous fluids and antibiotic therapy is essential in the peri-operative care pathway. If a risk assessment of predicted mortality identifies a >5% risk of death, then active input from the consultant surgeon and anaesthetist is required. Once surgery is indicated, it should be performed as soon as is practically possible following resuscitation, with direct input from both the consultant surgeon and anaesthetist. Early source control of sepsis, administration of IV antibiotics and intra-operative goal-directed fluid therapy are associated with improved patient outcomes. These patients should be managed in a critical care setting during their early post-operative recovery phase.

Involvement in the audit will undoubtedly improve the outcome of patients undergoing an emergency laparotomy within the Trust. Initial analysis of the data collected so far at the Trust, has shown an overall mortality for this cohort of patients at zero, well below the national average of 14.4%. We will focus our attention on this high risk group of very sick patients in what has traditionally been seen as the ‘Cinderella’ specialty of surgery.

Accurate and timely input of data is critical to this audit, and the bulk of the data can be uploaded live online by the on-call registrars and consultants in surgery and anaesthetics at the time of surgery. Please keep up the good work!

Footnote:

Further reading:


TRAUMA STUDY DAY: A REFLECTION

By Mandy Cox
Trauma Perioperative Practitioner

I recently attended the Trauma Study Day, organised by Trauma and Orthopaedic Senior Sister Naomi Rogerson with talks by Consultant Orthopaedic Surgeons Mr Panos, Junior Sister Leanne Irwin and Orthopaedic Practitioner Lisa Haswell, supported by Depuy Synthes. The various presentations covered the differences between uncemented versus cemented procedures; the anatomy of the hip and the types of hip fractures and surgery.

Trauma, especially hip fractures, is a complex field of surgery and it can be challenging to know all the special types of sets and instruments that can be used, especially if you do not know your anatomy in this field. As an assistant theatre practitioner, I am unable to ‘scrub in’ in this area because it is emergency surgery. I am a circulator in these theatres. However, I cannot ‘scrub’ for the elective orthopaedics. I often feel apprehensive, hoping I can retrieve the correct items requested in an instant. This can be exasperating, not only for me but also the scrubbed team.

The workshops helped me give an introduction to a common brand of sets and instruments used in trauma hip surgery. Although the training was not obligatory, it was an offering of extended training to enable us to be able to increase our knowledge in an informal and relaxed environment.

Gaining knowledge about implants and equipment was tremendously beneficial as was learning about the history of hip replacements and how things have developed. Study days like this make an enormous difference when working in theatre and if you comprehend the tools and implants, then you understand your role; it also makes it more interesting.

I have now reinforced my learning which will help me, not only on a theoretical level but also in practice when allocated to the trauma theatre ‘running’ for the scrubbed team and the perioperative orthopaedics in the future.

Regional BGS report

Dr Laura Ferrigan, Consultant Geriatrician

On 22nd May, SASH hosted the SW Thames Regional British Geriatric Society spring meeting. The theme of the afternoon was ‘Innovation in Geriatric medicine’. The programme was introduced by CEO Michael Wilson, who updated attendees on the developments to elderly medi-

Paul Simpson (Chief Financial Officer), commenced the afternoon programme with a financial introduction to elderly people’s services, de-
mystifying some of the complex financial aspects of the NHS and the pressures facing acute trusts.

We were urged as clinicians to engage with our finance teams, local GPs and CCGs, to ensure that the quality agenda had a sound clinical basis.

We were delighted to welcome James Munro, CEO of Patient Opinion, who provided an excellent talk on the use of Patient Opinion, who provided an excellent talk on the use of Patient Opinion for feedback to support, to ensure patients feel they have been heard.

Jeanne Waters, Associate gave a presentation reviewing the development of the Associate role in the UK, including their training, regulation and contribution to the medical team. SASH has been increasingly recognised as leading in PA development (articles in BGS newsletter June 2014 and ‘Adequate Physician Associate’ role in the SW Thames Regional BGS newsletter, June 2014) and the introduction to a common brand of sets and instruments used in trauma hip surgery.

Further reading:


IMPROVING IV FLUID MANAGEMENT

By Dr Harriet Cunningham
Consultant Geriatrician

One of the outcomes of a recent mortality review and indeed a patient complaint, was the incorrect prescription of IV fluids to a patient with renal failure. Anecdotally, we felt that as juniors we had not had much training in the practical manage-

ment of a patient’s fluid status and this has also been highlighted in audits on acute kidney injury. With recent NICE guidance on IV fluid prescription, we felt it was an opportunity time to undertake an audit of current practice and also explore in more detail how confident and skilled junior doctors are in fluid prescription.

Over a period of one month, we audited 100 adult inpatients on general medical and surgical wards against the NICE guidelines. This involved looking at the initial assessment of patient’s fluid status, the appropriateness of IV fluid prescriptions, the monitoring and recording of a patient’s fluid status, and whether patients had an IV fluid man-

agement plan. We also recorded any instances of fluid mismanagement that contributed to patient harm. Disappointing, but not necessarily surpris- ingly, we found that we are not meeting the NICE standards in our prescribing and management of IV fluids for resuscitation and maintenance purposes.

Alongside this we have undertaken a junior doc- tor survey to assess both the confidence of junior doctors in the management of IV fluid therapy, and their knowledge of the most up-to-date IV fluid guidance. This has shown, as we suspected, the majority of junior doctors are not as confident as they would like in the management of IV fluid therapy, most notably in the assessment of fluid status. Most have had limited, if any formal training in this area.

Based on our results, we are seeking to improve the quality of our inpatient IV fluid therapy man- age ment. The mainstay of this will be through increasing the training of medical students and junior doctors in IV fluid prescribing and manage- ment, starting with incorporating this area into the ward round simulation training for under-

graduate medical students, as well as the annual teaching curriculum for FY1 and FY2 doctors. In addition, we are exploring ways to improve the IV fluid prescription chart and the appropriateness of IV fluid prescriptions. We are optimistic that through such measures we can lead the way in improving the quality of our IV fluid management.

“Our patients have always talked about us, but ... in the era of social media this is now more transparent and visible”
The underlying crux of each pathway is the team approach with everyone working symbiotically to ensure our patients receive the best care possible. We have been praised at a recent assessment for our team approach and we aim to continue this high standard to be the best at what we do.

Footnotes:

SASH to become a Schwartz round® centre

SASH has recently been successful in bidding to become a Schwartz round® centre. Schwartz rounds originated in the United States and provide a monthly one hour session for staff from all disciplines to discuss difficult emotional, social issues arising from patient care. Developed by the Schwartz Center for Compassionate Healthcare in the US, they were piloted by the Kings Fund in the UK in 2010 with great success and promoted shared experience and learning. The Point of Care Foundation now leads the work in the UK and will be helping SASH by providing training and support as we introduce the rounds. The first round will be on Monday 13th October in the Postgraduate centre at 12.30 for a buffet lunch followed by the round at 13.30-12.30. All clinical staff are invited to attend and participate. Posters will go up nearer the time. Further information about Schwartz rounds can be found at www.theschwartzcenter.org.

By Natalie Powell
Consultant Physician

Clinical case

Acute Kidney Injury: The Outreach perspective

By Claire Rowley
Lead Nurse Critical Care Outreach Team

An 83 year old lady who had fallen at home had been in hospital following a shoulder replacement. She had a past medical history of asthma, hypertension, hiatus hernia and chronic renal failure which was monitored by her GP. Post-operatively her Early Warning Score (EWS) was 1. She was referred to CCOT three days later when her EWS was 9. We noted that she had been hypotensive for three days, with an EWS of over 5 for at least 36 hours and had had suboptimal hydration. Unsurprisingly, her blood tests revealed acute on chronic kidney injury (creatinine 30, creatinine 485). Her blood was also acidic as a result. She also had signs of a chest infection and was clinically unwell. Within a few hours she was moved to intensive care for additional monitoring and renal support and made a good recovery. She was moved back to ward care after six days and ultimately discharged home. So what can we learn from this case?

• It is crucial to respond to the EWS in a timely fashion, using the escalation referral pathway on the back of the EWS chart and asking for early specialist review.
• We must accurately monitor fluid input and output in patients at risk of acute kidney injury (AKI) e.g. post surgery.
• We must ensure adequate hydration (especially in elderly patients and those with impaired kidney function).
• We must be aware of a patient’s past medical history that might predict a risk of developing AKI.
• If patients are difficult to cannulate and the patient is at risk of AKI, call for help.
• Consider catheterisation but only if it aids fluid balance monitoring.

Suggested reading:
1. NICE Guidance CG169 Acute Kidney Injury August 2013

Outreach nurse Clare Rowley using the EWS to detect risk of AKI.

As the case before illustrates, many cases of acute kidney injury (AKI) in hospital are potentially preventable. AKI is seen in 13–18% of all people admitted to hospital. It is important, therefore, for all staff to be aware of its definition, when to predict its occurrence, how it can be prevented and how to manage it effectively.

ACUTE KIDNEY INJURY: PREDICT, PREVENT AND RECOGNISE EARLY

PREDICT

Measure creatinine and compare with baseline for all admissions if any of the following are likely:
- Over 65yrs
- History of renal, heart, liver disease or diabetes
- Neurological, cognitive problems or disability
- That might impair intake
- Hypovolaemia
- Nephrotoxic medications/contrast agents

PREVENT

Those that are at risk should have ongoing assessment and early response to change in kidney function or urine output

- Consider IV fluids for patients needing contrast for radiological investigations if at risk
- Review medications such as ACE inhibitors, ARBs and metformin in those with impaired renal function and those having contrast agents

RECOGNISE

Detect AKI using the AKIN/KDIGO staging

- Through assessment, clinical examination and medication review
- Clear management action plan including coiling of care of appropriate
- Early referral for specialist advice (twisting Renal Consultants, ITU)

Stages of AKI

1. Risk
2. Incipient
3. Acute
4. Chronic

Suggested reading:
Reflective practice

My journey to being a nurse

By Karen Archer
First year student nurse - Brook ward

I am fortunate to have diverse experience from working in mental health, to working at an orphanage in Romania. However, I originally embarked on my journey as a student nurse at East Surrey Hospital 20 years ago. Training was very different back then and perhaps the time was not right for me so I changed direction to work on the front line as an Ambulance Technician, this has been my role for the last 16 years.

Last year I took the plunge and went back into nursing at the University of Surrey. I am currently a mature student finishing my first clinical placement where I began my journey at East Surrey Hospital. Before starting I worried that nursing would not be the same due to changes over the years and perhaps I would spend less time with the patients.

On my first day I felt excited but anxious. When I saw the paper work needed for each patient, I felt daunted. I thought how would I remember to complete it all and how would this impact on my ability to deliver quality care to my patients? I was lucky to have a supportive ward manager as my mentor and the other nurses made me feel welcome and part of the team. This importantly, has given me the confidence to develop my clinical skills whilst juggling the daily administrative tasks.

Nursing today, I believe, demands strong academic foundations. We learn the importance of critical appraisal and the application of evidence-based practice. We learn the importance of autonomy in also questioning what it best for our patients. Reflection is a useful tool for the nurses, allowing us to ask whether we delivered the best care and how we might do things differently in the future.

I am sure my journey will have its frustrations and challenges, but I am already feeling valued for my contribution and know that this time is the right time for me.

The appraisal process is not designed to catch another Shipman but to promote reflective practice supported by quality assurance document has now been published and we are working together on this.

The quality of medical appraisals, as measured by detailed feedback of practice throughout the year and supporting information, ranges from awesome, to frankly completely inadequate. It would be far easier for doctors to populate a copy of the MAG with supportive information each month so that it is not a burden to produce at the end of the year, this needs to be on the radar for everybody a little more.

We have achieved the highest appraisal rates in the South East and this was acknowledged by Sir Keith Pearson in February this year (formerly Chairman of The NHS revalidation committee, now NHS England). The Framework for Quality Assurance document has now been published and we all have to comply with it. I have noticed that the ‘best’ appraisal documentation, with only a few exceptions, is invariably produced by the female medical staff who are far more engaged with the process. For those doctors who find the process difficult to grasp then this can be seen as an opportunity and know’s deserve to be seen by doctors who are on board. We must be receptive to the process of getting better.

REVALIDATION: FEMALE MEDICS LEAD THE WAY

By Mr Adam Stacey-Clear
Responsible Officer for GMC Revalidation

It is now a legal requirement for all doctors with a license to practice to have an annual appraisal. Indeed, all NHS employees need to have one. The NHS England guidelines stipulate that under exception of circumstances (e.g. maternity/sick leave or sabbatical) postponement of an annual appraisal must be agreed in advance with the RO.

The appraisal process is not designed to catch another Shipman but to promote reflective practice supported by quality assurance document has now been published and we are working together on this.

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Evidence based practice

Critical appraisal - A key tool for evidence based practice

By Susan Merner
Deputy Head of Library & Knowledge Services

Critical appraisal is a key skill which helps you reach evidence based decisions. Evidence Based Medicine is to Ask, Acquire, Appraise, Apply, Assess. As well as being able to assess articles retrieved from a literature search, it can also be used within journal clubs to discuss recent research and has also appeared as an extra challenge for junior doctors during OSCEs. Critical appraisal enables you to use a standard approach in assessing research – particularly useful when assessing a huge number as you need to avoid adding in your own personal bias. It enables you to focus on key parts of the article and ensures you appraise the statistical data, the methodology used and have a reasoned argument on whether the findings are valid.

Help is available by contacting the library – we can work with individuals and groups to look at how to appraise an article and we run workshops on this topic. Our website indicates useful resources and links – use Resources – Critical Appraisal to locate this information.

The CASP website1 is one of the links - ‘How to read a paper’3. Copies of the book are available in the library. We also have ‘The doctor’s guide to critical appraisal’ which offers a comprehensive review of the knowledge and skills needed to appraise clinical research papers.

Critical appraisal - a key skill which helps you reach evidence based decisions. Evidence Based Medicine is to Ask, Acquire, Appraise, Apply, Assess. As well as being able to assess articles retrieved from a literature search, it can also be used within journal clubs to discuss recent research and has also appeared as an extra challenge for junior doctors during OSCEs. Critical appraisal enables you to use a standard approach in assessing research – particularly useful when assessing a huge number as you need to avoid adding in your own personal bias. It enables you to focus on key parts of the article and ensures you appraise the statistical data, the methodology used and have a reasoned argument on whether the findings are valid.

1. www.intranet.nhs.uk/forms/medical online appraisal form

If you are feeling bewildered by the mention of meta -analysis or cohort studies there is a useful book to help make sense of this - ‘How to read a paper’3. Copies of the book are available in the library. We also have ‘The doctor’s guide to critical appraisal’ which offers a comprehensive review of the knowledge and skills needed to appraise clinical research papers.

Footnotes:  
DATIXWEB: CLOSING THE SAFETY ACTION LOOP

By Suzanne Robinson
Directorate Risk & Patient Safety Manager

What is the point of reporting incidents, we never get any feedback? This is a cry heard in hospitals around the world. “They do get feedback, they just don’t recognise it”, is the frustrated reply from the people who operate the incident reporting system.

One of the recommendations from the Francis report1, is that a culture of incident reporting by staff is not only encouraged but insisted upon. It means that staff should be entitled to feedback on anything they report, together with any information regarding the actions taken or the reasons for not acting.

Closing this ‘feedback loop’, which is not only about the feedback that has remained a challenge within the NHS. What has worked for these industries does not automatically transfer to healthcare, where we have far fewer automated processes and where the result of an error tends to have more immediate consequences.

Other industries agree that using different methods of feedback is the most effective way of informing staff. The introduction of DatixWeb gives us an opportunity to develop the system so it can supply the information required to feedback on actions taken and the improvements made, as a result of incident reporting, in a way that the organisation can evaluate.

Earlier this year, staff compiled a valuable survey regarding feedback on Datixweb. Whilst 39% of respondents thought that the feedback section was a useful addition to managing patient safety, 51% felt it was in need of some improvement. Sadly 9% felt it served no useful purpose at all.

This is disappointing because we know that there is so much good work and so many improvements happening every day, we just need to refine how we record and share them across the Trust.

Feedback on patient safety incidents is not just about information; it is very much about taking action too. Wherever we work in the hospital we all have a part to play, and the giving of feedback to improve how we all work for the benefit of our patients should be an integral part of patient safety management.

The feedback project is still very much a work in progress, as I continue to develop this part of the system for my MSc in Integrated Governance in Healthcare.

For further information of how to obtain feedback please contact suzanne.robinson@sash.nhs.uk.

“Unfortunately 87% of staff had not received any feedback when they reported an incident, even though they had requested it, so it is not surprising that staff feel disillusioned by the process.”

Lessons learned

Edited by Dr Ben Mearns
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You say Sepsis, I hear Septicaemia

Sometimes the terms that we use can be confusing to patients and their families. We all now use the term ‘sepsis’ to describe a pathophysiological response in the body to infection, that can range from a relatively mild reaction to one that can lead to organ failure and death. However, our family interpreted the term as meaning Septicaemia and based their assumptions of the patient’s care on this diagnosis which led to a complaint. Once the term was explained, the family felt so much better.

Lesson to learn: We need to explain medical terms in simple, accessible language to patients and their families and to confirm understanding.

Always check electrolytes when prescribing fluids

Most doctors will have been in the position of being handed a drug chart and asked to write up some more fluids. It can feel like a routine job and can be suggested to a doctor in passing. This happened one day on the Acute Medical Unit (AMU) and resulted in a helpful doctor writing up some ‘maintenance’ fluids which included potassium for a patient with high potassium levels and renal failure.

Potassium certainly should not have been prescribed and urgent treatment was necessary to correct the problem.

Lesson to learn: Drugs or fluid must only ever be written up for a patient when you know the case and have reviewed all necessary investigations. For fluid prescriptions, we need to always have checked the most recent electrolytes (see page nine for IV fluid audit action plan)

Pause when you prescribe

A patient was admitted with a very high INR due to a warfarin overdose. It became apparent that the patient had been taking 3.5mg of warfarin with good effect but at some point this had been reissued and a mistake was made. 5mg tablets were issued in place of the usual 0.5mg giving the patient a total dose of 8mg rather than their usual 3.5mg. This dose was given for several weeks and the INR had not been checked as it was considered to be stable. The patient was admitted with a G1 bleed with an INR of over 20 suggesting warfarin overdose.

Lesson to learn: We should ensure that when prescribing drugs we stop and look at the prescription once completed to ensure that everything is as it should be. The ward round checklist is a good reminder.

Footnotes:

Shhhhh!

A common theme has appeared in our patient feedback and we all need to try our best to improve it. Patients tell us that our wards are very noisy at night and that this can disturb their sleep. This is particularly a problem in assessment areas like the AMU and we need to try to fix it.

Lesson to learn: At night we need to speak quietly and away from patient areas if possible. We should check the phones on the ward and turn down the ringer volume and think before telephoning a ward at night, as the noise will disturb patients. Please let me know of any other suggestions.

Pitfalls with methotrexate

Methotrexate can be a particularly harmful drug and because it is prescribed and administered in a ‘once per week’ way we must ensure that we are vigilant whenever we use it. There have been two times in the last year when an error has occurred and additional doses of methotrexate given and we must all learn from these events to prevent them in future.

Lesson to learn: Remember that FY1 doctors should never prescribe methotrexate, even if rewriting the drug chart – get a senior doctor to do it. Remember to always block out the days that the dose should not be given on the drug chart. Remember not to allow boxes of methotrexate to remain in the patient’s own drug supply at the bedside. And please stand back after writing up the drug and check and check again that the prescription is correct. So please when prescribing methotrexate, think and think again.

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