
A reflection on 35 years of cases
I has been a team game.
Daryl OVSA 2022

Learning Objectives

- Assist you in reflecting how you are interacting with other local health care practitioners in providing effective health care.
- Add to the framework of treatment skills in your repertoire.
- Encourage you to analyse how you interact with other health care providers.

Classic Surgical Sieve – SRC 2011

as seen on House

- VITAMIN
- V: Vascular
- I: Infective/Inflammatory
- T: Trauma
- A: Auto-immune
- M: Metabolic
- I: Idiopathic/Iatrogenic
- N: Neoplastic

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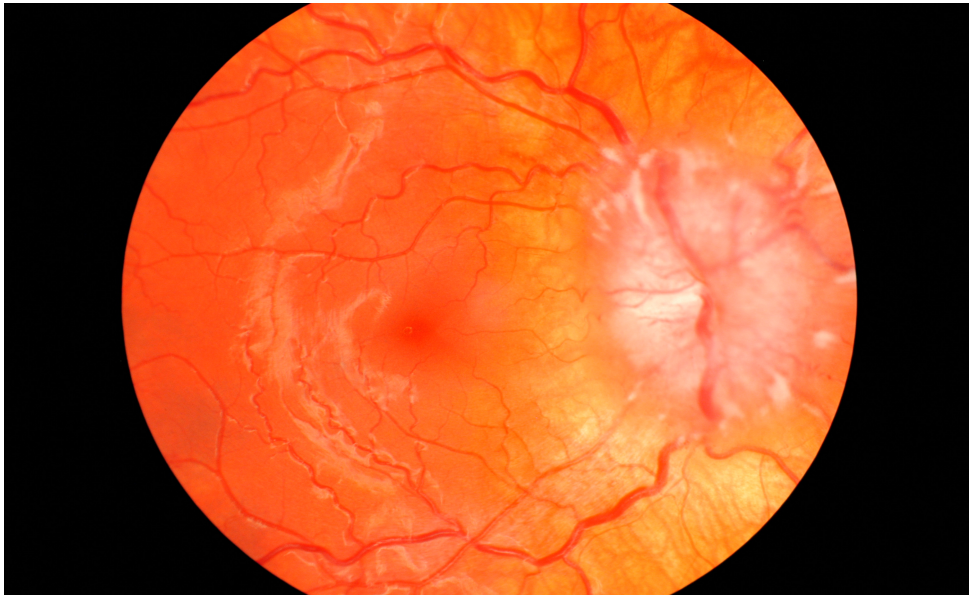
Purpose of a Sieve – SRC 2011

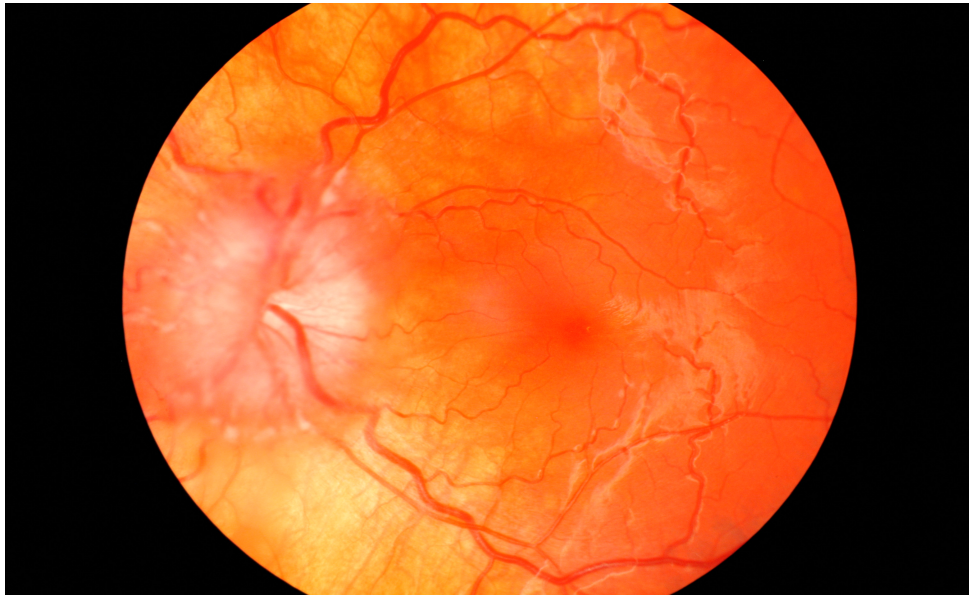
- Often by using a pneumonic as a guide, this is a process of exclusion to gain a diagnosis rather than the clinician leaping to a conclusion.

- A surgical sieve refers to a very general list of diagnostic or pathological headings, against which any finding can be compared.

Why bother with a Sieve? – SRC 2011

Some conditions are obvious, but what is the cause?





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In daily clinical practice how do we diagnose? – SRC 2011

- 18 second rule: *that's the average time it takes a doctor to interrupt you as you're describing your symptoms. By that point, he/she has in mind what the answer is, and that answer is probably right 80% of the time.* Dr Jerome Groopman *How Doctors Think*

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- 5% of US autopsies find lethal diagnostic errors. Diagnostic errors – the next frontier for patient safety. JAMA Volume 301 (10) 11 March 2009, p1060-1062

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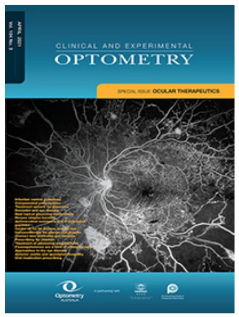
- Rather than look at how you stop getting things wrong it is better to look at how you can get things right.



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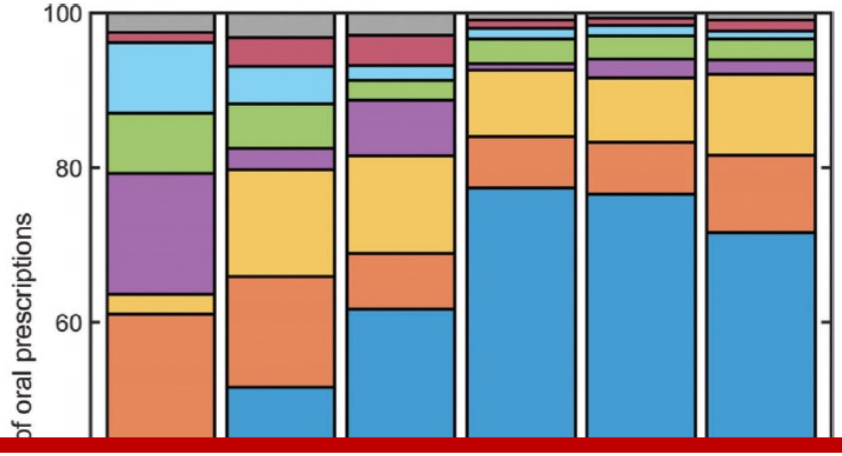

The most prevalent of these was the macrolide antibiotic, azithromycin, which alone represented 39 per cent of all prescribed oral medications. Other prescribed antibiotics included tetracyclines, such as doxycycline (18 per cent) and minocycline (1.0 per cent), and the penicillin-group antibiotic, amoxicillin (1.8 per cent).

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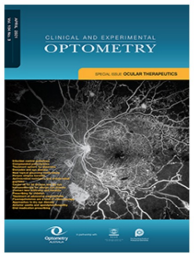

Clinical and Experimental Optometry

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/tceo20

Oral medication prescribing by optometrists in New Zealand

Philip RK Turnbull & Jennifer P Craig

Omeprazole, a proton pump inhibitor (PPI), was prescribed 63 times, comprising 1.5 per cent of the total prescribed medications.

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Preseptal cellulitis vs Orbital cellulitis

Examination	Preseptal cellulitis	Orbital cellulitis
Symptoms	• Unilateral • Tenderness, erythema and swelling of lids and periorbital area • May be a mild fever • Often recent history of sinusitis/local skin abrasions or bites	• Unilateral • Rapid onset of erythema and swelling • Severe pain associated with blurred vision ± diplopia • Fever, headache, systemic malaise
Signs	• Erythema with tense oedema, may not be able to open lid • Tenderness • Normal or just slightly blurred visual acuity	• Lid erythema and oedema ± reduced periorbital sensation • Pain • Usually reduced visual acuity • Painful ophthalmoplegia – reduced eye movements (due to toxic myopathy & oedema) • May be evidence of optic neuropathy eg optic disc oedema • May be proptosis (usually laterally and downwards - may be obscured by lid swelling)
Additional notes	Eye itself may be slightly injected but is otherwise relatively uninvolved.	Other positive findings may include conjunctival chemosis and injection, a purulent discharge and evidence of endophthalmitis.

Help the GP with what this is NOT

http://www.patient.co.uk/doctor/orbital-and-preseptal-cellulitis

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Which Bug

TABLE 1

Diagnosis of conjunctivitis by age

Age groups	Common etiology	Treatment	
Neonates	<24 hours	Chemical conjunctivitis	Observation
	<1 week	*Neisseria gonorrhea*	Hospitalize, ceftriaxone
	1–2 weeks	*Chlamydia trachomatis*	Oral erythromycin
Infants and toddlers	Without otitis	*Haemophilus influenzae, Streptococcus pneumoniae, Branhamella catarrhalis*	Topical antibiotics (Polysporin* or Polytrim†)
	With otitis	*H. influenzae*	Oral antibiotics
School-age children	1–5 years	HSV, varicella–zoster conjunctivitis	Topical antivirals, oral acyclovir
School-age children		Viral conjunctivitis	Supportive care, artificial tears
and adolescents		Allergic conjunctivitis	Antihistamines, decongestants, H_1, antagonists, mast cell stabilizers, NSAIDS

*Monarch Pharmaceuticals, Bristol, TN.
†Allergan, Irvine, CA.
HSV = herpes simplex virus; NSAIDS = nonsteroidal antiinflammatory drugs.

Teoh D and Reynolds Diagnosis and management of pediatric conjunctivitis Pediatric Emergency Care Vol19 No 1 2003

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The Royal Children's Hospital Melbourne

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Clinical Practice Guidelines

RCH > Health Professionals > Clinical Practice Guidelines > Antimicrobial guidelines

In this section

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CPG index

Antimicrobial guidelines

SCV Safer Care

This guideline has been adapted for statewide use with the support of the Victorian Paediatric Clinical Network

Preseptal (periorbital) cellulitis Mild	Group A streptococci *S. aureus* *H. influenzae* spp.	Cefalexin 33 mg/kg (500 mg) oral tds	7–10 days Bilateral findings and/or painless or non-tender swelling in a well looking child is more likely to be an allergic reaction
Moderate		Flucloxacillin[3] 50 mg/kg (2 g) IV 6H ***or*** Ceftriaxone 50 mg/kg (2 g) daily (for hospital-in-the-home)	
Severe, or not responding, or under 5 years of age and non-Hib immunised	As above plus *H. influenzae* type b[6]	Flucloxacillin[3] 50 mg/kg (2 g) IV 6H ***and*** 3rd gen cephalosporin[4]	IV duration based on severity and improvement (usually 3-4 days) 10 days minimum total duration

https://www.rch.org.au/clinicalguide/guideline_index/Antibiotics/

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Limiting Bacterial Resistance

To prevent and control the spread of antibiotic resistance, health professionals can:

- Prevent infections by ensuring your hands, instruments, and environment are clean.
- Only prescribe and dispense antibiotics when they are needed, according to current guidelines.
- Report antibiotic-resistant infections to surveillance teams.
- Talk to your patients about how to take antibiotics correctly, antibiotic resistance and the dangers of misuse.
- Talk to your patients about preventing infections (for example, vaccination, hand washing, safer sex, and covering nose and mouth when sneezing).

https://www.who.int/news-room/fact-sheets/detail/antibiotic-resistance

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Practice points

- **Carefully consider if a health condition is self-limiting before prescribing antibiotics:** Antibiotics are not recommended as routine therapy for acute otitis media, acute tonsillitis, acute sinusitis or acute bronchitis, all of which mostly resolve on their own.
- **When antibiotics are necessary, prescribe the narrowest-spectrum antibiotic at the appropriate dose and duration:** Consult relevant guidelines for appropriate dose and duration depending on the site and type of infection, and choose the narrowest-spectrum antibiotic to treat the likely pathogen.
- **Provide clear instruction to patients regarding appropriate use and disposal of prescribed antibiotics:** Ensure patients understand the directions provided, to reduce the risk of treatment failure or relapse. Advise them to return unused antibiotics to the pharmacy for disposal

https://www.nps.org.au/news/antibiotic-resistance-in-australia-here-and-now

Amoxicilin/clavulanate (Augmentin) – penicillinase

- Disrupts bacterial cell walls – bateriocidal
- 500mg TID for a week
- Side effects:
  - Contraindicated where there is reported penicillin allergy
  - Oral/vaginal thrush
  - GI upset
  - May reduce effectiveness of oral contraceptive
  - etc
- Okay for kids
- Pregnancy catergory B

Cefalexin (Keflex) - floroquinolone

- Fluoroquinolones work by inhibiting the action of enzymes that participate in cutting and supercoiling of double-stranded DNA that are required for the synthesis of bacterial mRNAs and DNA replication.
- 500mg BID for a week.
- Contraindications
  - 1% cross reactivity with penicillin allergy
  - Must differentiate between GI upset and true allergy (IgE mediated response)
  - Vitamin K absorption alteration
  - unpleasant symptoms when alcohol is consumed (Disulfram like reaction)
- Safe in pregnancy

Doxycycline (Vibramycin) - tetracycline

- Inhibits bacterial protein synthesis
- Anti infective 100mg BID po for 10 days
- Anti inflammatory 50mg (?) BID for a month then daily for 1 to three months.
- Not for kids under 8 years old; category D for pregnancy/breastfeeding
- Side effects:
  - GI upset (take with food)
  - Photosensitivity
  - Pseudotumor Cerebri
  - etc

Azithromycin (Zithromax) - macrolide

- Inhibits bacterial protein synthesis
- 500mg Day then 250mg for the following four days
- Side effects
  - GI upset
  - Headache
  - Rash
  - May exacerbate myasthenia gravis
  - Etc
- Pregnancy Category B
- Note erythromycin a cheaper alternative – restricted benefit in Aus

Alleviating GI upset associated with oral antibiotics

- "We conclude that there is sufficient evidence to make a recommendation for the use of specific probiotic products for the prevention of antibiotic associated diarrhea. In particular, we provide a three-star recommendation for preparations with a minimal daily dose of 2 × 10^9CFU of the probiotic strain *Lactobacillus rhamnosus* GG." *V Agamennone et al BMC Gastroenterology(2018)*

- *"*Potentially, probiotics maintain or restore gut microecology during or after antibiotic treatment through receptor competition, competition for nutrients, inhibition of epithelial and mucosal adherence of pathogens, introduction of lower colonic pH favoring the growth of nonpathogenic species, stimulation of immunity, or production of antimicrobial substances." *S Hempel et al JAMA (2012)*

- "The overall evidence suggests a moderate protective effect of probiotics for preventing AAD (NNTB 9, 95% CI 7 to 13)" *Q Guo Cochrane (2019)*

- Do GP's suggest probiotics???

And it goes something like this….

Optom: I need to talk to Dr Clare.

GP receptionist: What is the matter that you wish to talk to Dr Clare about.

Optom: It is about a patient and the GP wanted me to talk to her about it.

GP receptionist: what is the matter?

Optom: look, the GP specifically asked me to talk to her and that is what I am doing.

GP receptionist: who are you BTW????????

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I S B A R

IDENTITY OF PATIENT
- Name/Age/MRN/ward/team

SITUATION
- Symptom/problem
- Patient stability/level of concern

BACKGROUND
- History of presentation
- Date of admission and diagnosis
- Relevant past medical hx

ASSESSMENT & ACTION
- What is your diagnosis/ impression of situation?
- What have you done so far?

RESPONSE & RATIONALE
- What you want done
- Treatment/investigations underway or that need monitoring
- Review: by whom, when and of what?
- Plan depending on results/clinical course

And yourselfA

J.M.O. HANDOVER PROJECT
ROYAL NORTH SHORE HOSPITAL

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Case

- Jerry Hall Aet 63
- Represented for review with sore gritty eyes – patient on ocular lubircants, warm compress and massage of lids and FML BD (prescribed by you)
- Meds Metropolol, symbocort, FML
- VA right (+0.50/-0.25 X 90) 6/6 left (+4.50/-0.50 X 22) 6/18
- PERL (-ve) RAPD, L SOT 10PD concomitant, Gross stereo only (fly), motility full, VF's full to confrontation
- MGD grade 3 with assicaited marked inferior corneal staining
- Anterior chamber quiet but 0.3 angles
- NC/NO 01.
- DFE C/D R 0.33 L0.25. OCT no red. A/V 2/3. Three drusen in the superior temporal retinal of the RE 8DD out. Maculae flat, foveal reflex present in both eyes. LE small amount of pigment clumping at the macula.
- IOP's RE 12, LE 13 with iCare at 2:15pm
- Assessment – all other findings as previous. Lid therapy not improving symptoms or signs.
- Try Doxy therapy next to see if can alleviate MGD – contact GP

1

Before phoning have in front of you;

Medication chart, allergies and Resident's clinical notes and End of Life wishes

INTRODUCTION/ IDENTIFY – Your name, designation, Resident's name, DOB, Gender, location and who you intend to direct your call to;

SITUATION – what has happened/ when did it happen, how long and what are the critical signs;

BACKGROUND – Resident's relevant medical history – how long has he/ she been unwell;

ASSESSMENT – results of your physical assessment of the Resident/ vital signs/ conscious state/ type of injury post fall/ neurological observations/ BSL if appropriate – pain-acute/ chronic/ site/ intensity/ type;

RECOMMENDATIONS – what is the clinical need for the Resident.

Have you told the Clinician about the Resident's End of Life Wishes?

2

After the phone call, please note;

- Name and phone of Clinician/ Health Service and time of call;
- Date and time of booked appointment, if confirmed;
- Immediate instructions/ actions as advised by the Clinician until the Resident is seen;
- Monitor and record the Resident condition for changes;
- Contact family/ Medical Power of Attorney, as required.

https://www.wnswphn.org.au/uploads/documents/corporate%20documents/WHAL%20RACF%20ISBAR%20Framework_FINAL.pdf

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- Tell the story

"I'll tell you the story…"

"I'll give you the background information…"

- Provide RELEVANT information only. Deciding what is relevant is a skill that comes with experience

- Don't forget 'less is often more'

– you may get the message across better with less Information

- Include aspects of history, examination, investigations and management where relevant

- Note: the **relevant** information needs to be delivered slowly and simply with appropriate emphasis and repetition

Southern health & VMIA training package

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BMJ Open

Impact of the communication and patient hand-off tool SBAR on patient sa

Mart
Wolf
Klingberg,[1]

To cite: Müller M, Jürgens J, Redaèlli M, *et al*. Impact of the communication and patient hand-off tool SBAR on patient safety: a systematic review. *BMJ Open* 2018;**8**:e022202. doi:10.1136/bmjopen-2018-022202

descriptive reduction in patient outcomes.

Conclusions This review found moderate evidence for improved patient safety through SBAR implementation, especially when used to structure communication over the phone. However, there is a lack of high-quality research on this widely used communication tool.

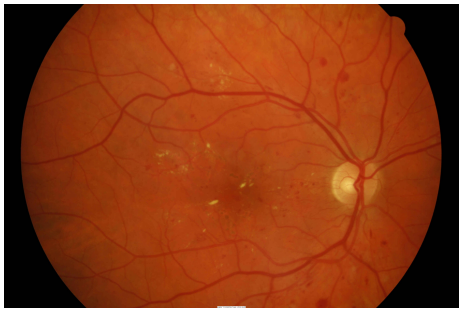
Trial registration none

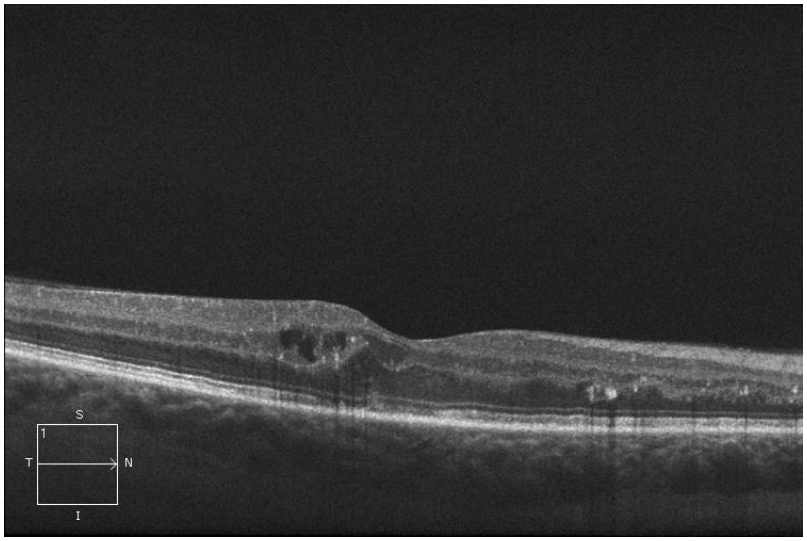
ABSTRACT

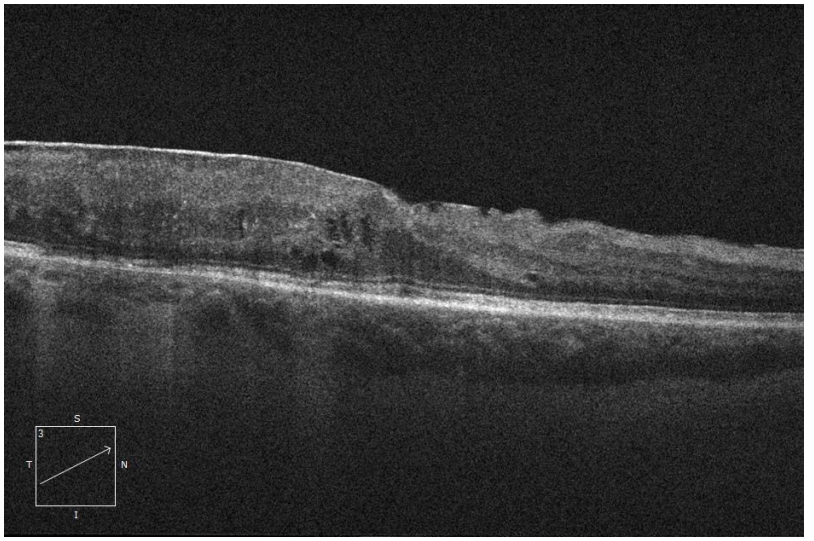
Objectives Communication breakdown is one of the main causes of adverse events in clinical routine, particularly in handover situations. The communication tool SBAR (situation, background, assessment and recommendation) was developed to increase handover quality and is widely assumed to increase patient safety. The objective of this review is to summarise the impact of the implementation

Strengths and limitations of this study

- This systematic review was conducted in accordance with the Cochrane Collaboration standards using a validated tool for quality assessment of the identified studies.
- Five well-known databases as well as the referenc-







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May 2017

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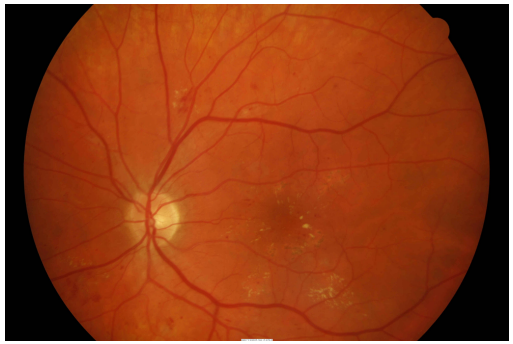

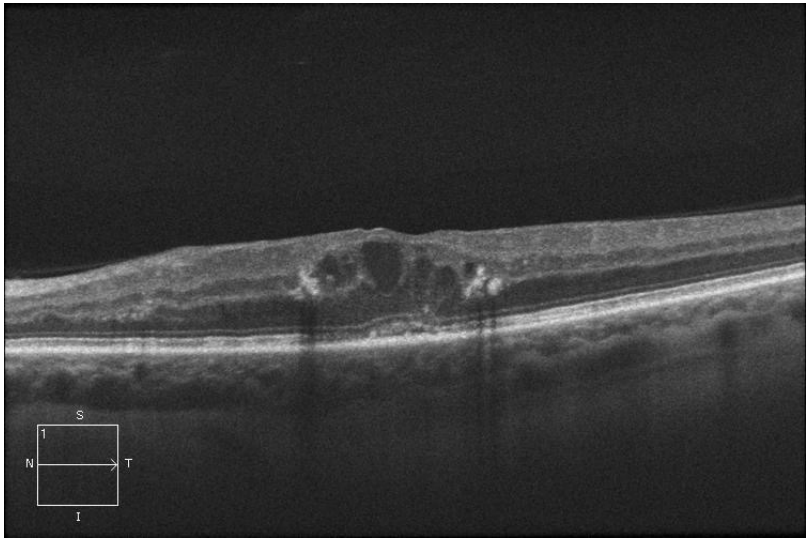

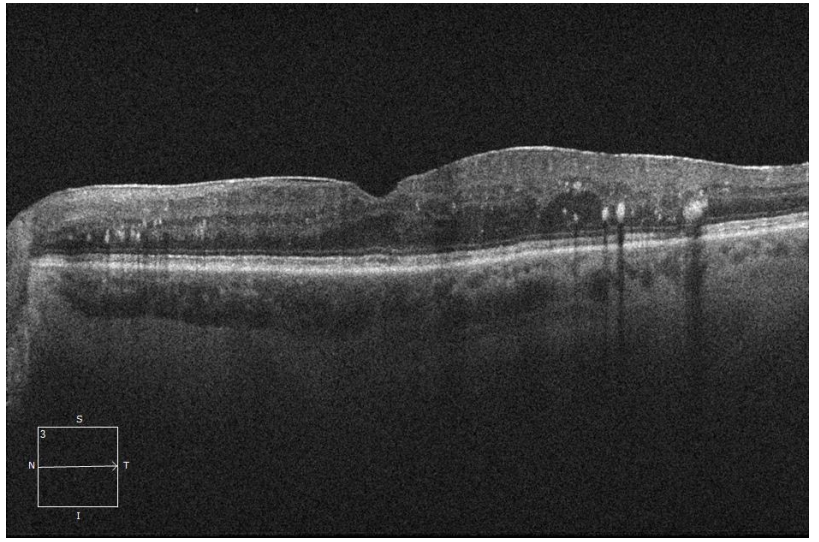

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