Surrey and Sussex NHS
Healthcare NHS Trust

TRUST BOARD IN PUBLIC	**Date: 25th May 2017** **Agenda Item:**	
REPORT TITLE:	Compliance with Nasogastric Tube Misplacement Patient Safety Alert	
EXECUTIVE SPONSOR:	Fiona Allsop	
REPORT AUTHOR (s):	Kim Rayment	
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Executive Committee & CQRM	
Action Required:		
Approval ( )	**Discussion (√)**	**Assurance (√)**

Purpose of Report:

The purpose of the report and attachments is to provide assurance to the Trust Board that the actions required by the Patient Safety Alert regarding the continued risk of harm due to nasogastric (NG) tube misplacement have been completed, the alert closed and an appropriate action plan developed to ensure all the safety-critical requirements are met and completion of the actions to achieve this is monitored via the Nutrition Steering Group and the Patient Safety Committee.

Summary of key issues

The patient safety alert referred to previous alerts sent out in 2005; 2011; 2012; and 2013 regarding the risk of harm relating to NG tube misplacement. Harm resulting from NG tube misplacement is listed as a Never Event (Revised Never Events Policy and Framework March 2015)

The alert required completion of an assessment in accordance with a number of safety-critical areas identified from analysis of nationally reported incidents and previous alerts. As a result of the assessment within SASH, a number of areas required action and an action plan has been developed to address these.

The areas for action include; review of the previous Trust Policy and development of a revised policy; review of current equipment used for NG tube placement to improve safety and support best practice; competency based training for nurses and doctors; review and revision of clinical documentation; and development of on-going audit of compliance.

The action plan will be monitored via the Nutrition Steering Group and the Patient Safety Committee until completion.

Recommendation:

The Board are asked to take assurance from the report that the requirements of the Patient Safety Alert have been completed and the on-going actions resulting from the assessment have been identified and are being monitored until completion.

Relationship to Trust Strategic Objectives & Assurance Framework:	
SO1: Safe – Deliver safe, high quality care ***and improving*** services which pursue perfection and be in the top ***25% of*** our peers **SO2:** Effective – As a teaching hospital, deliver effective and improving ***sustainable*** clinical services within the local health economy	
Corporate Impact Assessment:	
Legal and regulatory impact	Ensures the Board are aware of current and new requirements
Financial impact	Impact of patient safety incidents on finances and resources
Patient Experience/Engagement	Highlights how best clinical practice improves patient experience
Risk & Performance Management	Identifies possible future risks which the Board should consider
NHS Constitution/Equality & Diversity/Communication	Compliance with NHS Constitution
Attachment:	
Combined Baseline assessment against N NG Tube Patient Safety Alert - Baselin NHS-PSA-Re-2016-006 Nasogastric Tube I NG tube safety letter_NHS England a	

TRUST BOARD REPORT – (25th May 2017)
Compliance with Nasogastric Tube Misplacement Patient Safety Alert

1. Background

Use of misplaced nasogastric and orogastric tubes was first recognised as a patient safety issue by the National Patient safety Agency (NPSA) in 2005 and three further alerts were issued by the NPSA and NHS England between 2011 and 2013. Misplacement and use of a naso- or oro-gastric tube in the pleura or respiratory tract where the misplacement of the tube is not detected prior to commencement of feeding, flush or medication administration is listed as a Never Event by NHS England. Never Events are considered 'wholly preventable where guidance or safety recommendations that provide strong systemic protective barrier are available at a national level, and should have been implemented by all healthcare providers.'

1.1 Context

National

In July 2016 NHS Improvement sent out a patient safety alert regarding the continued risk of harm due to nasogastric (NG) tube misplacement. The alert highlights that despite the number of alerts circulated 95 incidents were reported nationally between September 2011 and March 2016. It is acknowledged that this needs to be considered in the context of over 3 million nasogastric or orogastric tubes being used in the NHS in that period, but concluded that the reported incidents show that risks to patient safety persist.

Local

During this timeframe SASH reported 1 incident in March 2015, where a child was admitted for replacement of an NG tube after an episode of vomiting at home. The child had complex health needs and was under the care of the Royal Brompton and Royal Marsden hospitals. The main error type identified involved the nursing staff completing incorrect placement checking; poor communication between the nurse and parents; and use of the NG tube which was later found to be misplaced. This resulted in pneumonia and an extended length of stay for the child. As a result of this incident a wide range of learning was identified and actions completed to improve the patient safety processes and reduce the chances of a similar incident occurring.

Safety recommendations

Analysis of the 95 reported incidents by NHS Improvement reinforced how essential the tube placement checks are in preventing harm. The clinical reviewers of the reported incidents showed that misinterpretation of x-rays by medical staff that did not appear to have received competency-based training was the most common error type. Other error types involved nursing staff and PH tests, unapproved tube placement checking methods and communication failures resulting in tubes not being checked. All of which had been identified as areas of concern in previous alerts and suggested to NHS Improvement problems with organisational processes for implementing recommendations and actions from alerts. In light of these conclusions the Patient Safety Alert circulated in July 2016 was directed at Executive and Board level.

2. Work completed

Fiona Allsop, Chief Nurse, was identified as the named Executive Director. A steering group was established to undertake an assessment against the safety-critical

requirements identified in the referenced resource set of the alert. The assessment completed by the steering group included adult, paediatric and neonates.

The key areas that required action included; review and revision of the Trust policy; review of the equipment currently in use and compliance with safety standards; review of current competency-based training for nurses and doctors, revision of that as required and roll out of new competency-based training for nurses and doctors; review and revision of clinical documentation and roll out of new documentation; and set up of clear audit programme against compliance. An action plan was developed by the steering group which will be monitored via the nutrition steering group and the patient safety committee.

The revised combined enteral policy has been approved by the members of the Patient Safety Committee and key stakeholders and ratified by the Executive Committee. The competency-based training for doctors and nurses has been reviewed and a new training programme is being rolled out. There is a proposal paper supporting the change of current NG tubes and equipment to a new device which provides additional safety features and a training package to support nurses and doctors competency training.

3. Recommendation

The Board are asked to take assurance that the nasogastric tube misplacement risk is being adequately managed, there are appropriate control measures in place and the actions required by the alert have been completed and gaps identified as a result of the work have been developed into an appropriate action plan which is being monitored appropriately.

Fiona Allsop
Chief Nurse
May 2017