Public - Board of Directors

Subject:	Patient Safety Alert – Nasogastric Tube Misplacement	**Date:** 13th April 2017
Prepared By:	Paul White, Risk Manager	
Approved By:	Paul Moore, Director of Governance & Quality Improvement	
Presented By:	Paul Moore, Director of Governance & Quality Improvement	

Purpose		
To update the Board of Directors on the results of a self-assessment against resources provided in a Patient Safety Alert issued by NHS Improvement concerning the risks associated with misplacement of nasogastric tubes, and to summarise the resultant action plan.	**Decision**	
	Approval	✓
	Assurance	✓

Strategic Objectives				
To provide outstanding care to our patients	**To support each other to do a great job**	**To inspire excellence**	**To get the most from our resources**	**To play a leading role in transforming health and care services**
✓				

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		✓		

Risks/Issues	
Financial	None identified.
Patient Impact	Risk of avoidable patient harm if safety critical requirements are not met.
Staff Impact	Additional training provision may be required in order to comply with the Alert.
Services	None identified.
Reputational	Potential for damage to Trust reputation if CAS Alerts are not responded to promptly and appropriately.

Committees/groups where this item has been presented before

Patient Safety & Quality Board (April 2017).

Executive Summary

In July 2016 NHS Improvement issued a Patient Safety Alert entitled **Nasogastric Tube Misplacement: continuing risk of death and severe harm.** The Alert followed analysis which showed that in England, between September 2011 and March 2016, 95 incidents involving a misplaced nasogastric or orogastric tube were reported where fluids or medication were inadvertently introduced into the respiratory tract or pleura. NHS England have identified that the misinterpretation of x-rays by medical staff, who did not appear to have completed competency-based training required by a previous alert issued in 2011, as the most common causal factor and raise a concern regarding the implementation of alerts within the NHS. For this reason, the Alert issued in July 2016 was directed for action by trust boards.

The Alert was accompanied by a resource set which trusts were directed to review and consider as part of a centrally coordinated self-assessment into the robustness of existing systems for supporting staff to deliver safety-critical requirements for initial nasogastric and orogastric tube placement checks. Following the self-assessment trusts are required to produce an action plan that is summarised in the form of a public Board paper and shared with commissioners.

On behalf of the Board, a comprehensive self-assessment has been undertaken. This has been reviewed and challenged robustly by the Patient Safety & Quality Board in April 2017 and an action plan agreed. This process has considered the Trust's position from both adult and paediatric patient perspectives and has been a helpful exercise in highlighting where there are opportunities to strengthen or clarify existing arrangements. Appropriate actions have been agreed to address these issues and implementation underway.

The main areas of focus for the action plan are as follows:

- A review of existing guidelines and supporting documentation to ensure that all safety critical requirements are explicitly covered and made Trust policy
- A review of training provision and record keeping both within the Trust and in liaison with the Joint Royal College of Physicians Training Board (JRCPTB), to include the provision of training for the interpretation of x-ray following insertion of NG & OG tubes
- A review of governance arrangements for monitoring compliance with policy and implementation of improvement plans
- Strengthening of the existing policy for the procurement of medical equipment
- Embedding the use of Patient Safety Alerts within the incident investigation process

Progress with implementation of these actions will continue to be monitored through the PSQB in accordance with the established process for managing the Trust's response to CAS Alerts, and will as part of the action plan involve seeking assurances from divisional teams that medical staff can demonstrate completion of training and competence.

A copy of the Action Plan is attached to this report as **Appendix I**.

A copy of the full Self-Assessment is also attached for reference, as **Appendix II**.

A copy of the original Patient Safety Alert is attached as **Appendix III.**

Recommendation

(i) It is recommended that the Board of Directors ensure progress is kept under review by the Quality Committee until such time as the Quality Committee and Board are satisfied that full compliance is demonstrated.

Action Required by the Board

The Board of Directors are invited to:

(i) receive and note the outcome of the Trust's self-assessment in respect of the implementation of this alert;
(ii) note that the self-assessment has helpfully highlighted opportunities to strengthen internal control and actions have been agreed in respect of those opportunities;
(iii) advise on any further action required by the Board; and
(iv) consider and approve the recommendation.