University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper O

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 6 April 2017

COMMITTEE: Quality Assurance Committee

CHAIR: Colonel (Retired) Ian Crowe, Non-Executive Director

DATE OF MEETING: 30 March 2017

This report is provided for the Trust Board's information in the absence of the formal Minutes, which will be submitted to the Trust Board on 4 May 2017.

SPECIFIC RECOMMENDATIONS FOR THE TRUST BOARD:

- **Quality Account** - the Committee formally supports and recommends to the Trust Board for endorsement: (a) release of the Draft Quality Account to external stakeholders for their comments and (b) final sign off of the Quality Account at the Trust Board meeting on 1 June 2017 (Paper L).

- **Patient Safety Alert – Nasogastric Tube Misplacement** - the Committee received assurances that corrective actions had been taken regarding a NPSA Alert NPSA/PSA/RE/2016/006. This matter will be fully recorded in the minutes of the QAC meeting of March 2017 (Paper S) reported to the Trust Board on 4 May 2017.

SPECIFIC DECISIONS:

- None noted.

DISCUSSION AND ASSURANCE:

- **Disabled Patient Parking at the LRI** – the Committee received a report detailing the current provision of disabled parking spaces for patients. Currently 9.8% of parking spaces were allocated for disabled use at the LRI and 12% across the Trust. The LRI provision would reduce to 8% temporarily during ED Phase 2. It was noted that the Trust currently provides a greater percentage of public disabled parking spaces than recommended by the Department of Health guidance, local planning requirements or the Disabled Parking Award. The report also detailed plans for future provision. In discussion of this item it was agreed that a verbal update would be provided at the next QAC meeting regarding provision of parking spaces outside the Windsor Building to address the loss of spaces outside Balmoral Building, during Phase 2 of the ED build. The update would also address any necessary changes in the provision of the Trust's buggy service.

- **Data Quality and Clinical Coding** – the Committee received a quarterly update on data quality and clinical coding indicators. With regards to the Data Quality Maturity Index produced by NHS Digital, it was noted that compared to peers UHL was ranked 2nd for completeness and range of dataset for the quarter July to September 2016. To date this year 23 of the Trust's clinical coders

had had their work audited, which overall had accumulated to a good Information Governance Toolkit (IGT) score of Level 2. Coders from NUH were due to visit the Trust in May 2017 to recode a sample of UHL notes alongside UHL staff coding the same notes to identify any variances in coding. UHL coders would then do the same piece of work with Nottingham clinical notes. In this way best practice would be shared. By July 2017 it was anticipated that agency coders would cease as the UHL team became fully staffed.

- **Month 11 Quality and Performance Update for discussion on patient experience and quality issues** – the Committee received a briefing on quality and performance for February 2017. The following points were highlighted:-
  - *(a) MRSA* – there had been two suspected unavoidable MRSA cases detailed in the report, but these had been confirmed as third party allocations and the report would be subsequently updated to reflect this;
  - *(b) Ambulance Handover 60+ minutes* – performance of 6% had been achieved for February 2017, which was last seen in June 2016;
  - (c) *Never Events* – none had been reported for the month;
  - (d) *Pressure Ulcers* – there were no Grade 4 pressure ulcers reported this month and Grade 3 pressure ulcers remained within the month and year to date trajectories;
  - (e) *Diagnostic 6 Week Wait* - remained compliant;
  - (f) *Single Sex Accommodation Breaches* – there was a reduction in breaches (4 breaches in February 2017) from the previous month when 6 breaches were reported. Thorough investigation and reporting of each breach occured;
  - (g) *Mortality* – the latest published SHMI is 101, and
  - (h) *Fractured Neck of Femur* – 67.6% of patients were operated on within the 35 hour target in February 2017. A long-term solution was being identified to increase theatre capacity.

- **Estates and Facilities Services Progress Update** – the Committee received the second quarterly Estates and Facilities performance report to provide assurances on the provision of services across the Trust. Following feedback on the previous report a number of additional metrics had been included. There was a notable improvement in patients receiving their meals on time which was helping with protected meal times. In consideration of this report, it was agreed that a summary of the key areas of improvement and challenges would be produced and included in the May 2017 Chief Executives Briefing. It was also agreed that further indicators such as on fire and waste would be added to the next iteration of the report.

- **Assurance Report re: CQC Action Plan** – the Committee received a updated report on the CQC compliance actions developed in response to the Trust inspection report, following a CQC inspection in June 2016. The Committee noted that monthly progress reports would be provided to the EQB in the form of an actions tracker. The action plan had been submitted to the CQC and other partners, including the CCG's and NHSI. The action plan was positively received by the CQC at the Quality Summit which took place on 28 March 2017. Evidence would be required for each action before they could be closed, and this was currently being sought and confirm and challenge was taking place. In consideration of this report it was agreed that the Director of Clinical Quality would write to the CQC to receive written confirmation that they were content with the action plan and the actions the Trust were taking to gain assurance that actions were on track. A future report would include actions for how to move to 'good'. The Trust had been nominated for piloting the Well-led Domain. The Chief Executive would include a summary of the Quality Summit in his briefing to staff.

- **Assurance Report for EWS and Sepsis** – members received an update on the work programme being undertaken to improve the care of patients with a deteriorating Early Warning Score (EWS) and Red Flag Sepsis trust-wide. Following the sepsis team appointment, improvements had been made with the IV antibiotics indicator within an hour which would be seen in the improved performance in the April 2017 report. There had also been some improvements made at ward level. The sepsis pathway was due to be relaunched imminently. Following an application to the National Patient Safety Awards for sepsis, the Trust had been shortlisted. Work was underway to further improve performance and to digitalise data require to report on indicators.

- **Draft Quality Account** – the committee received the draft Quality Account 2016/17, which had

been produced following national guidance and followed a similar structure to the previous year. A section had been included regarding Patient Partners. The paper was being presented to QAC as a draft prior to circulation to external partners for a 28 day feedback period, following which it would be externally audited by KPMG. KPMG would audit two of the indicators in the report around patient safety and clostridium difficile to gain assurance re the process rather than the target. It would then be formally signed off at the Trust Board meeting on 1 June 2017. It was noted that the report did not include the full year performance due to the timescales for dissemination. The Committee suggested no changes to the document prior to circulation to external partners.

- **Quality Assurance of CIP Programme – Month 10 2016/17** – the cost improvement programme for 2016/17 was coming to a conclusion and no new adverse impacts on quality from the schemes had been identified other than what had already been reported in previous reports. The main focus was now on identifying 2017/18 schemes, with a planned completion date of May 2017. As in previous years, the CCGs would receive a presentation on 2017/18 schemes. The Committee received assurances that some schemes had been rejected on the grounds of an impact on quality, and a discussion took place on one such scheme in outpatients. Leicester City CCG colleagues had recently visited the Trust and received assurances around the CIP process.

- **Nursing and Midwifery Quality and Safe Staffing Report (January 2017)** – no wards had triggered as a Level 3 concern and 7 wards had triggered as a Level 2 concern. One ward at LGH continued to trigger as a particular concern to the Chief Nurse and Corporate Nursing Team. It was noted that these concerns were not around safety. Following a recent visit from the CCG and NHSI an updated action plan had been produced. The Trust had seen a reduction in applications from European nurses following the Brexit announcement, although there had been a recent intake of nurses from Italy. Successful completion of the IELTS requirement was proving challenging. There would be a new fee introduced re overseas nurses which would equate to £1,000 for 3 years per nurse. HCA recruitment continued to be successful, and an open day on 4 March 2017 attracted over 350 attendees. The Nursing Associate programme had commenced with a cohort of 50. The Infection Prevention metrics continued to be challenging, but the Corporate Infection Prevention Team were providing support to improve practice and performance. There was a discussion around continuing professional development for nursing staff.

- **Reports from the Director of Clinical Quality including (1) Involving employees in improving standards of care, and (2) update on progress being made with the review of UHL policies and guidelines** – the first section of the report detailed the quarter 3 2016/17 data for sources of how staff had raised concerns internally and externally. The Committee were assured by the relatively low number of concerns. It was noted that since the publication of this report there had been three CQC whistleblowing complaints in January 2017. In discussion of this item it was noted that the Freedom to Speak Guardian had now been appointed. The second section of the report provided an update on progress being made with reviewing policies and guidelines past their due date. It was noted that this would be reported on quarterly in the future.

- **Patient Safety Alert – Nasogastric Tube Misplacement** – a gap analysis had been produced against the standards identified in the alert. Work will be monitored through the Nutrition and Hydration Committee. The Committee received assurances that a scoping exercise had been undertaken in relation to NPSA Alert NPSA/PSA/RE/2016/006 and that corrective actions had been taken. This would be fully recorded in the minutes of the QAC meeting of March 2017 (paper S) reported to the Trust Board on 4 May 2017.

- **Friends and Family Test Scores (January 2017)** – received and noted. There was limited discussion due to time constraints, but it was noted that the 5% Outpatient coverage target had been achieved for the month with the use of SMS texting.

- **The following reports were received and noted by the Committee for information:**

    - Executive Quality Board Minutes from 7 March 2017
    - Executive Performance Board Minutes from 21 February 2017

- QAC Calendar of Business

- **IG Compliance** – it was also noted under any other business that the Trust had achieved its annual Information Governance training target of 95%, and Estates and Facilities were commended for their contribution in achieving this target.

DATE OF NEXT COMMITTEE MEETING: 27 April 2017

Colonel (Retired) Ian Crowe – Non-Executive Director and QAC Chair 30 March 2017

Patient Safety Alert Nasogastric Tube Misplacement: Continuing Risk of Death and Severe Harm NHS/PSA/RE/2016/006

Author: Michael Clayton, Head of Safeguarding and Jeanette Halborg, Head of Nursing
Sponsor: Carole Ribbins, Deputy Chief Nurse

Paper Q

Executive Summary

Please note this paper has embedded documents which will not be visible, but if you require a copy please contact the author

Context

In July 2016 NHS Improvement issued a National Patient Safety Alert in relation to the risk of Nasogastric Tube misplacement. All NHS Trusts were asked to review their current systems and process against revised guidance to provide a position statement to the Trust Board. This work has been completed, together with an associated action plan.

Questions

1. Through the scoping work undertaken is the Trust compliant with the NHS/PSA/RE/2016/006?
2. What outstanding actions need to be completed to ensure compliance?

Conclusion

1. A scoping exercise has been undertaken against the NHS/PSA/RE/2016/006 CAS Alert (Appendix 1), using the recommended "Resource set Initial placement checks for nasogastric and orogastric tubes July 2016" attached to the CAS alert. Appendix 2 contains the evidence and identifies gaps in compliance where an action plan has been produced.
2. The exercise identified three areas where further work is required in relation to ensuring that the actions arising from a previous NPSA alert in 2011 are completed, development of an assessment framework and the revision and creation of the Paediatric and Neonatal Nasogastric policy. An action plan has been developed and progress will be monitored through the Trust Nutrition and Hydration Assurance Committee. Appendix 3.

Input Sought

The Board is requested to confirm that it is satisfied that the evidence identified in Appendix 2 and the supporting action plan in Appendix 3 provides assurance that the CAS alert NHS/PSA/RE/2016/006 can be closed by 21st April 2017 as the required 5 step actions are complete as identified in Appendix 1.

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Not applicable
Consistently meeting national access standards	Yes
Integrated care in partnership with others	Not applicable
Enhanced delivery in research, innovation & ed'	Not applicable
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Yes
Financially sustainable NHS organisation	Not applicable
Enabled by excellent IM&T	Not applicable

2. This matter relates to the following **governance** initiatives:

Organisational Risk Register	No
Board Assurance Framework	Yes

3. Related **Patient and Public Involvement** actions taken, or to be taken: Not applicable

4. Results of any **Equality Impact Assessment**, relating to this matter: Not applicable

5. Scheduled date for the **next paper** on this topic: To be monitored through the Trust Nutrition and Hydration Assurance Committee

6. Executive Summaries should not exceed **1 page**. My paper does comply

7. Papers should not exceed **7 pages.** My paper does comply

NHS Improvement

Patient Safety Alert

Nasogastric tube misplacement: continuing risk of death and severe harm

22 July 2016

Alert reference number: NHS/PSA/RE/2016/006

Alert stage: Two - Resources

Use of misplaced nasogastric and orogastric tubes[1] was first recognised as a patient safety issue by the National Patient Safety Agency (NPSA) in 2005[2] and three further alerts were issued by the NPSA and NHS England between 2011 and 2013.[3-5] Introducing fluids or medication into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube is a Never Event. 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.'[6]

Between September 2011 and March 2016, 95 incidents were reported to the National Reporting and Learning System (NRLS) and/or the Strategic Executive Information System (StEIS) where fluids or medication were introduced into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube. While this should be considered in the context of over 3 million nasogastric or orogastric tubes being used in the NHS in that period,[7] these incidents show that risks to patient safety persist. Checking tube placement before use via pH testing of aspirate and, when necessary, x-ray imaging, is essential in preventing harm.

Examination of these incident reports by NHS Improvement clinical reviewers shows that misinterpretation of x-rays by medical staff who did not appear to have received the competency-based training required by the 2011 NPSA alert is the most common error type. Other error types involve nursing staff and pH tests, unapproved tube placement checking methods, and communication failures resulting in tubes not being checked. The reports included 32 incidents where the patient subsequently died, although given many patients were critically ill before the tube was introduced, it is not always clear whether the death was directly related to the misplaced tube.

Review of local investigations into these incidents suggests problems with organisational processes for implementing previous alerts. This Patient Safety Alert is therefore directed **at trust boards** (or their equivalent in other providers of NHS funded care) and the processes that support clinical governance. It is NOT directed at frontline staff. Some of the implementation issues identified were:

- problems with systems to ensure staff who were checking tube placement had received competency-based training
- problems with ensuring bedside documentation formats include all safety-critical checks
- problems maintaining safe supplies of equipment, particularly radio-opaque tubes and CE-marked pH test strips.

The resource set that accompanies this alert provides a range of support for trust boards (or their equivalents) to assess whether previous nasogastric tube guidance has been implemented and embedded within their organisations improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes. It includes briefings to help non-executives and governors to understand the issues, summaries of safety-critical requirements of past alerts, self-assessment/assurance checklists, and learning from reported incidents.

Actions

Who: All organisations where nasogastric or orogastric tubes are used for patients receiving NHS-funded care

When: To commence as soon as possible and to be completed by 21 April 2017

1. Identify a named executive director* who will take responsibility for the delivery of the actions required in this alert.
2. Using the resources supplied with this alert, undertake a centrally co-ordinated assessment of whether your organisation has robust systems for supporting staff to deliver safety-critical requirements for initial nasogastric and orogastric tube placement checks.
3. If the assessment identifies any concerns, use the resources supplied with this alert to develop and implement an action plan to ensure all safety-critical requirements are met.
4. Share this assessment and agree any related action plan within relevant commissioner assurance meetings.
5. Share the key findings of this assessment and the main actions that have been taken in the form of a public board paper.**

* For organisations that are not trusts/foundation trusts and do not have executive directors, a role with equivalent senior responsibility should be identified.

**For organisations without a board, an equivalent publically available alternative to a board paper should be identified eg a report on a public-facing website.

See page 2 for references

Alert reference number:	NHS/PSA/RE/2016/006
Alert stage:	Two - Resources

Resources

Patient safety incident reporting

For detail of dates and search strategy within the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS) see page x of the supporting *initial placement checks for nasogastric and orogastric tubes resource set* on the NHS Improvement website improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes

References

1. Hanna G, Phillips, L, Priest O & Zhifang N (201) Improving the safety of nasogastric feeding tube insertion A report for the NHS Patient Safety Research Portfolio July 2010 www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS048ImprovingthesafetyofnasogastricfeedingtubeinsertionREVISEDHannaetal.pdf
2. National Patient Safety Agency - Reducing the harm caused by misplaced nasogastric feeding tubes 2005 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59794&p=4
3. National Patient Safety Agency Patient Safety Alert: Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants 2011 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=129640
4. National Patient Safety Agency Rapid Response Report: Harm from flushing of nasogastric tubes before confirmation of placement 2012 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=133441
5. NHS England Patient Safety Alert: Stage 1 - Placement devices for nasogastric tube placement DO NOT replace initial placement checks 2013 www.england.nhs.uk/wp-content/uploads/2013/12/psa-ng-tube.pdf
6. NHS England Never Events Policy and Framework 2015 www.england.nhs.uk/patientsafety/never-events/
7. Page 9 of the supporting *initial placement checks for nasogastric and orogastric tubes resouirce set* on the NHS Improvement website improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes

Stakeholder engagement

- Medical Specialities Patient Safety Expert Group
- Children and Young People's Patient Safety Expert Group
- Surgical Services Patient Safety Expert Group
- Patient Safety Steering Group

For details of the membership of the NHS Improvement patient safety expert groups and steering group see www.england.nhs.uk/ourwork/patientsafety/patient-safety-groups/

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Patient Safety Alert Nasogastric Tube Misplacement: Continuing Risk of Death and Severe Harm NHS/PSA/RE/2016/006

REF	ACTION	RESPONSE/ACTION TAKEN	COMPLETED ON	EVIDENCE
1	Identify a named executive director who will take responsibility for the delivery of the actions required in this alert.	Responsible Director is Julie Smith, Chief Nurse	Complete July 2016	
2	Using resources supplied with the Alert, undertake a centrally co-ordinated assessment of whether the organisation has robust systems for supporting staff to deliver safety critical requirements for initial nasogastric and orogastric placement checks.	This has been completed by J Halborg, M Clayton and C Steele using the guidance and checklist produced by NHS Improvement the following actions have been taken in the following areas.	March 2017	
		National safety guidance The National Guidance requires all patient safety incident investigations relating to Nasogastric/ orogastric tube insertion,. Should reference national and local guidance and best practice. The Head of Patient Safety has confirmed in the attached e mail	March 2017	 Fwd NPSA guidance.msg
		Safe Equipment • All nasogastric/orogastric tubes supplied to the Trust continue to be compliant with the NPSA 2011 Alert. There have not been any changes to the procurement process which have changed the specification of nasogastric and orogastric tubes.	March 2017	

REF	ACTION	RESPONSE/ACTION TAKEN	COMPLETED ON	EVIDENCE
		The Trust senior procurement manager has been contacted to confirm that all PH paper continues to be supplied from MERCK and has a CE mark via e mail. Verbal confirmation has been given however confirmation via email is still required.	March 2017	 FW Re NG tube CAS alert.msg The current adult policy "Insertion and Management of Nasogastric and Nasojejunal Tubes in Adults" Approved July 2016 by the UHL policy and guidelines committee clearly states in Appendix 2 section 5 that Merck is the only PH paper with CE markings that should be used to test the PH of aspirate.
		n the previous NPSA 2011 Alert there were some outstanding actions. These will be followed up via the Trust Nutrition and Assurance group via the NHS/PSA/RE/2016/006 action plan as attached	March 2017	Confirmation of supporting evidence provided by email format from Richard Manton Risk and Assurance manager UHL. This included an Action plan and CAS alert final response. See below Action plan from 2011 CAS Alert

REF	ACTION	RESPONSE/ACTION TAKEN	COMPLETED ON	EVIDENCE
				Action Plan NPSA-2011-PSA002 A Signed off assurance repot for CAS alert in 2011 MDD1 Form for RRR signed by Eleanor Me Update and revised action plan for 2017 in relation to Current NHSI CAS alert. Document in Alert Nasogastric Tube Mis
		<u>Local Policies and Protocols</u> • The policies and procedures have been reviewed by the Trust's Lead Dietician who has confirmed that they are compliant with the NPSA Alert requirements. The Adult policy was approved in July 2016 The Paediatric and neonatal policy is subject to review and will be completed by July 2017, a copy of the work in draft is attached as evidence. See attached action plan for time lines	July 2016 July 2016 July 2017	Copy of Adult NG Policies. Nasogastric and Nasojejunal Tubes in . The Paediatric and neonatal policy is subject to review and will be completed by July 2017 as identified in the action plan

REF	ACTION	RESPONSE/ACTION TAKEN	COMPLETED ON	EVIDENCE
				Insertion and Management of NG &
		Competency Based Training • The Assistant Chief Nurse (Education) has confirmed Leicester Clinical Assessment Tool (LCAT) is a validated process that is used to assess staff competency. • Tailored training is provided to staff if required on nasogastric/orogastric tubes by the CMG Educational Leads. • When Staff are on local induction to a new area, the manager should determine the essential competencies required from the member of staff and ensure the required tailored training and development is provided. This should also take place as part of annual appraisal and more frequently if required.	March 2017 March 2017 March 2017	Reference Page 5 of the policy "Insertion and Management of Nasogastric and Nasojejunal Tubes in Adults" Approved July 2016. ***4.2 Senior Clinical Management Teams;*** *CMG Heads of Nursing, Deputy Heads of Nursing and Matrons alongside & Head of Service are responsible for ensuring CMG clinical teams are trained and competent and are aware and familiar with*

REF	ACTION	RESPONSE/ACTION TAKEN	COMPLETED ON	EVIDENCE
		• The current adult policy "Insertion and Management of Nasogastric and Nasojejunal Tubes in Adults" Approved July 2016 by the UHL policy and guidelines committee defines the roles and responsibilities of each professional group, and describes step by step the process for insertion and management of a nasogastric tube. This is supplemented for those patients that have a nasogastric / nasojejunal tube with a bespoke care plan Appendix 12. • Appendix 14 of the Adult NG policy contains a checklist for radiologists to complete following a request to check tube placement.	July 2016	*this policy* Copy of Adult NG Policies. Nasogastric and Nasojejunal Tubes in . The Paediatric and neonatal policy is subject to review and will be completed by May 2017 as identified in the action plan Insertion and Management of NG &
		<u>Clinical Documentation and Checklists</u> • There are patient checklists and care plans in place for adult patients as outlined in appendix 12 • The Paediatric and neonatal policy is subject to review and will be completed by July 2017 as identified in the action plan		Copy of Adult NG Policies. Nasogastric and Nasojejunal Tubes in . Copy of draft paediatric policy

REF	ACTION	RESPONSE/ACTION TAKEN	COMPLETED ON	EVIDENCE
				Insertion and Management of NG &
		Ongoing Audit of Compliance • An audit against the NHSI Alert was completed in July 2016		Audit results against the NHSI alert NGT misplacement compliance audit Jan Snap shot audit by dietetic and nutritional service of number of patients on NG feeding and who inserted NG tubes. NG audit 2017.xlsx
3	If the assessment identified any concerns, use the resource supplied with the Alert to develop and implement an Action Plan to ensure all safety critical requirements are met.	Action Plan is in place and was approved at the Trust UHL Nutrition and Hydration Assurance Committee on the 15-3-2017.		Update and revised action plan for 2017 in relation to Current NHSI CAS alert. Document in Alert Nasogastric Tube Mis
4	Share this assessment and agree any related action plan with relevant commissioner assurance meetings.	A report will be shared through the Trust's CCG quality review meetings CQRG		NG Assurance Trust Paper.docx Update and revised action plan for 2017 in relation to

REF	ACTION	RESPONSE/ACTION TAKEN	COMPLETED ON	EVIDENCE
				Current NHSI CAS alert. Document in Alert Nasogastric Tube Mis Copy of NHSI CAS alert Patient_Safety_Alert _Stage_2_-_NG_tube
5	Share the findings of this assessment and main actions that have been taken in the form of a public board paper	Board paper		NG Assurance Trust Paper.docx Update and revised action plan for 2017 in relation to Current NHSI CAS alert. Document in Alert Nasogastric Tube Mis Copy of NHSI CAS alert Patient_Safety_Alert _Stage_2_-_NG_tube

Patient Safety Alert Nasogastric Tube Misplacement: Continuing Risk of Death and Severe Harm NHS/PSA/RE/2016/006

Action Plan March 2017

To be reviewed monthly by the UHL Nutrition and Hydration Assurance Group:

No	Summary Actions	Progress / Update
1	To ensure that all outstanding actions from the NPSA NG Action Plan 2011 are complete and signed off by the UHL Nutrition and Hydration Assurance Committee	On review of the actions from the previous NPSA alert, here are currently 4 Amber and 1 Red actions which are not signed off in 2011. The policy owners are no longer working in the organisation, and have been assigned to new action owners
2	To ensure there is a Trustwide compliant Paediatric and Neonatal NG policy which includes a care pathway, training and competence guidance and procedure checklist	On review the Paediatric NG policy expired in May 2015. Currently there is not a neonatal NG policy. This action has been assigned to a policy lead in the Childrens Hospital
3	To develop a competency checklist for the insertion of NG tubes, as part of the LCAT assessment process	Discussion has been initiated with Assistant Chief Nurse Education to progress this

Specific Actions-

Status key:	**5**	Complete	**4**	On track	**3**	Some delay – expect to completed as planned OR implemented but not fully embedded	**2**	Significant delay – unlikely to be completed as planned	**1**	Not yet commenced	**0**	Objective Revised

Actions	UHL Status	Lead for actions	Actions required	Timescales	RAG
To ensure that all outstanding actions from the NPSA NG Action Plan 2011 are complete and signed off by the UHL Nutrition and Hydration Assurance Committee	In progress	M Clayton / J Halborg Corporate Nutritional Leads	a) Assign an action owner to all red and amber actions in the 2011 plan b) Request update reports from the new action owner to the Nutrition and Hydration Assurance Committee until action complete	March 31st 2017 May 2017	**4**

Actions	UHL Status	Lead for actions	Actions required	Timescales	RAG
To ensure there is a Trustwide compliant Paediatric and Neonatal NG policy which includes a care pathway, training and competence guidance and procedure checklist	In progress	C Stafford Matron Women's and Childrens CMG	a) Update and expand current paediatric policy to incorporate neonatal practice b) Confirm approval via the Trust Policy and Guideline Committee c) Request update reports from the new action owner to the Nutrition and Hydration Assurance Committee until action complete	May 2017 July 2017 April 2017	4
To develop a competency checklist for the insertion of NG tubes, as part of the LCAT assessment process	In progress	M Clayton	a) To identify an education lead to develop a competency framework for NG tube insertion	May 2017	4