Patient safety in nutritional care

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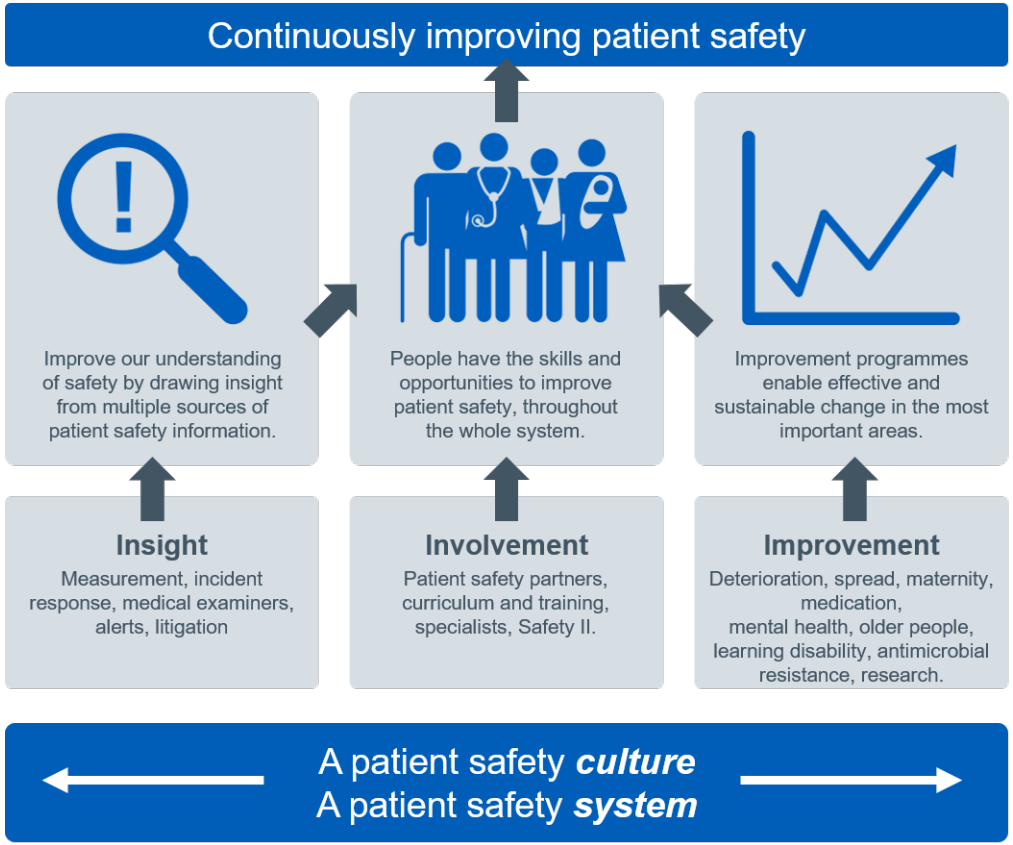
NHS England and NHS Improvement



Focus of the national patient safety team within the much broader remits of NHS England and NHS Improvement

https://improvement.nhs.uk/resources/patient-safety-strategy/

MHRA
Regulating Medicines and Medical Devices

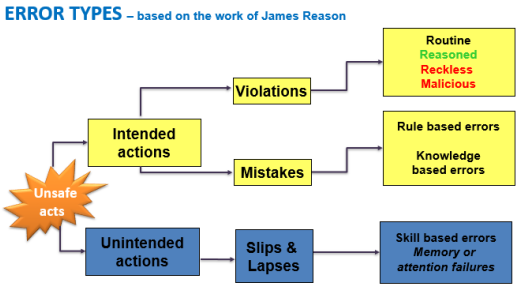
GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Ystadau Arbenigol
Shared Services Partnership
Specialist Estates Services

NHS National Services Scotland

NHS Improvement

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

CareQuality Commission

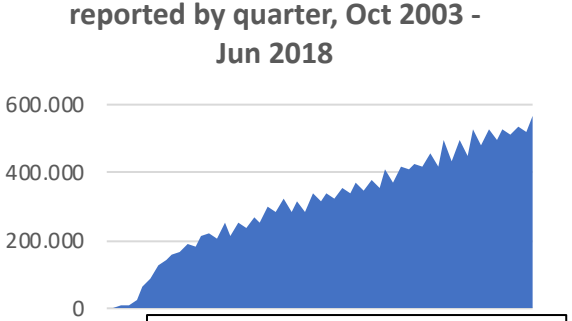


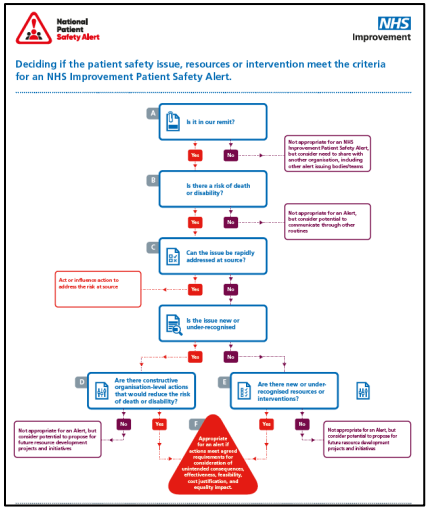
Who does what in patient safety:

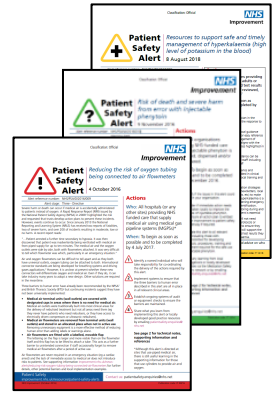
- MHRA for regulatory aspects of prescription products & device safety (UK)
- NHS Improvement Estates and Facilities for catering standards nationally (with partners for UK)
- CQC provider inspection/regulation (England)

NHS Improvement & NHS England patient safety team specialise in national action to reduce or eliminate human error

Our sources for national patient safety advice and guidance, including Alerts

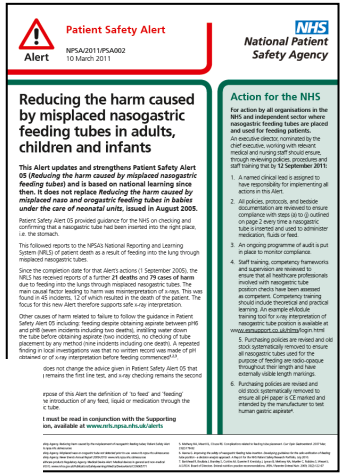


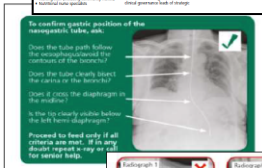


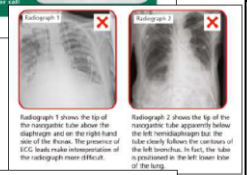


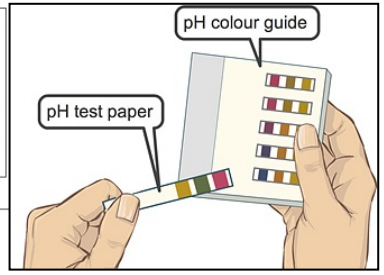
https://improvement.nhs.uk/resources/patient-safety-alerts/
https://improvement.nhs.uk/resources/patient-safety-review-and-response-reports/

National learning: nasogastric tube safety









Documentation following X-ray should include:

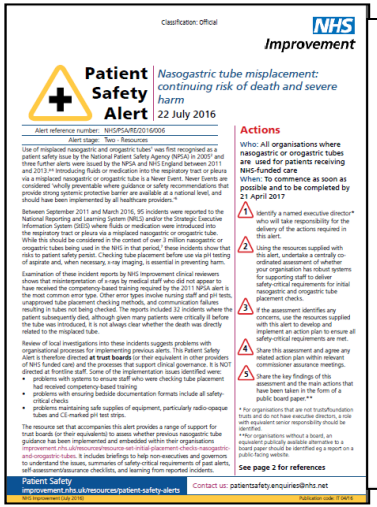
- Who confirmed the position of the nasogastric tube and evidence they are competent to do so
- Confirmation that any x-ray viewed was the most current x-ray for the correct patient
- How the position of the nasogastric tube was interpreted using the 'four criteria' e.g. *NG tube follows path of oesophagus, bisecting bronchi, remains midline to level of diaphragm and deviates to left thereafter. Tip is seen about 7cm below diaphragm*
- Clear instructions as to required actions e.g. *NG tube safe to use for feeding*

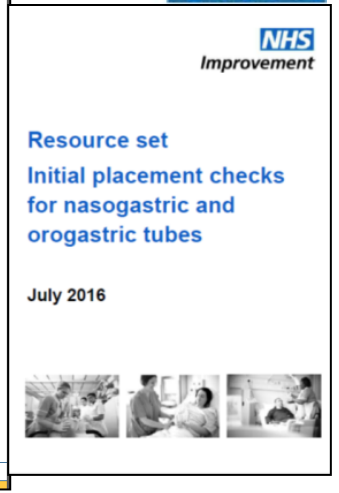
Action for the NHS

For action by all organisations in the NHS and independent sector where nasogastric feeding tubes are placed and used for feeding patients.

An executive director, nominated by the chief executive, working with relevant medical and nursing staff should ensure, through reviewing policies, procedures and staff training that by **12 September 2011:**

1. A named clinical lead is assigned to have responsibility for implementing all actions in this Alert.
2. All policies, protocols, and bedside documentation are reviewed to ensure compliance with steps (a) to (j) outlined on page 2 every time a nasogastric tube is inserted and used to administer medication, fluids or feed.
3. An ongoing programme of audit is put in place to monitor compliance.
4. Staff training, competency frameworks and supervision are reviewed to ensure that all healthcare professionals involved with nasogastric tube position checks have been assessed as competent. Competency training should include theoretical and practical learning. An example eModule training tool for x-ray interpretation of nasogastric tube position is available at www.esrsupport.co.uk/nlms/login.html
5. Purchasing policies are revised and old stock systematically removed to ensure all nasogastric tubes used for the purpose of feeding are radio-opaque throughout their length and have externally visible length markings.
6. Purchasing policies are revised and old stock systematically removed to ensure all pH paper is CE marked and intended by the manufacturer to test human gastric aspirate[4].





2005: ban air auscultation & litmus paper
2011: CE marked pH paper, tubes opaque throughout length, structured 'four criteria' x-ray interpretation
2012: no water flush before pH test
2013: do not confirm via magnetic traces
2016: leadership action to consistently ensure staff competencies

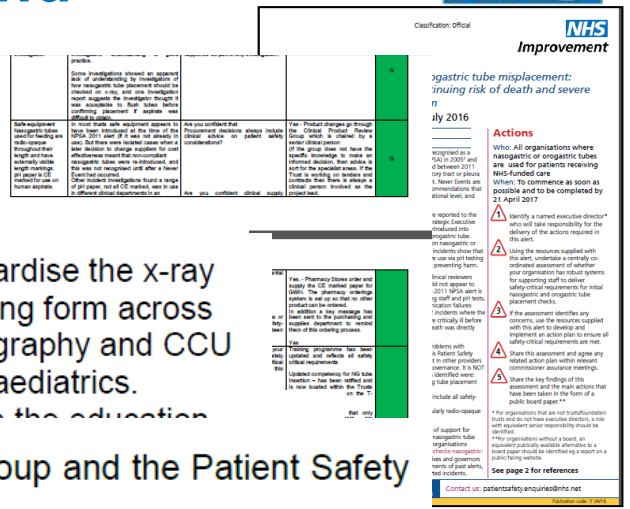
What other learning isn't being shared across countries?

What else could we learn from each other at this conference about current evidence on safest practice?

https://www.youtube.com/user/0x2020

…and if you are from a trust in England

Of the 15 patients that required an X-ray to confirm placement, 5 had good and accurate documentation by a Senior House Officer or above, 5 had no accurate or no documentation of placement, 2 patients had a naso-gastric tube placement and x ray, but the naso-gastric tube was then identified as no longer required and not used. 2 patients had documentation by nursing staff in the medical notes stating the naso-gastric tube was safe to use after taking verbal instruction from a doctor. 1 patient had the verification of a naso-gastric tube placement by a doctor, an FY1, with no senior confirmation.



2.3 The Trust policy 'Naso-Gastric Tubes for Placeme v5.0' did not contain a competency assessmer competency assessment has since been written a Education Group and the Clinical Education Group competency checked and formally recorded.

1. Standardise the x-ray reporting form across Radiography and CCU and Paediatrics.

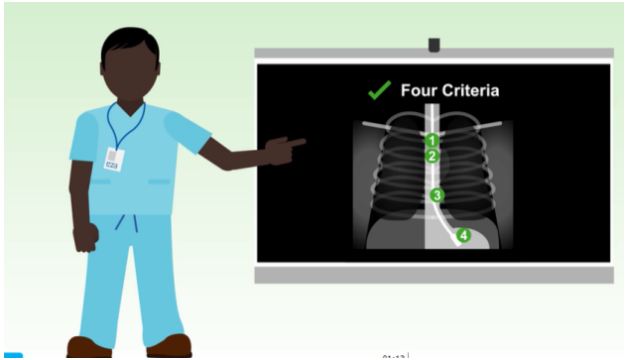
The action plan will be monitored via the Nutrition Steering Group and the Patient Safety Committee until completion.

till morning to reduce risks unless no/poor access for fluids/meds.

approac … staff that are required to evidence competence in confirma … efore, an e-learning module, accessible via OLM has been added to the Medical Mandatory training matrix. The assessment within the e-learning module is based around interpretation of chest x-ray films. Compliance and uptake will be captured by OLM and a training report can be downloaded from OLM. Medical staff are also actively encouraged to access face-to-face training provided by the CPD Team which includes insertion and placement verification exclusive of chest x-ray interpretation.

New NG tube policy is available on Staff Intranet and has been communicated in recent general information bulletin. New policy has also been sent to Senior Sisters/Charge Nurses. The new policy has been drafted in	Policy for Supplier Representatives in place http://cgov2/POLUP/PolUploads/20150622100847O.Supplier%20Representative%20Policy%20June%202015.pdf and	nasogastric tube placement by pH or x-ray have been assessed as competent through theoretical and practical learning? Nasogastric Tube	New policy references the new documentation that is required to be in place at the patient's bedside which includes safety-critical checks.	Snapshot audit for nursing undertaken September 2016 and Action Plan from audit includes BAU activities that require completion by 30/11/16. This includes 'Regular audits (minimum

Implementation isn't easy: nasogastric tube safety



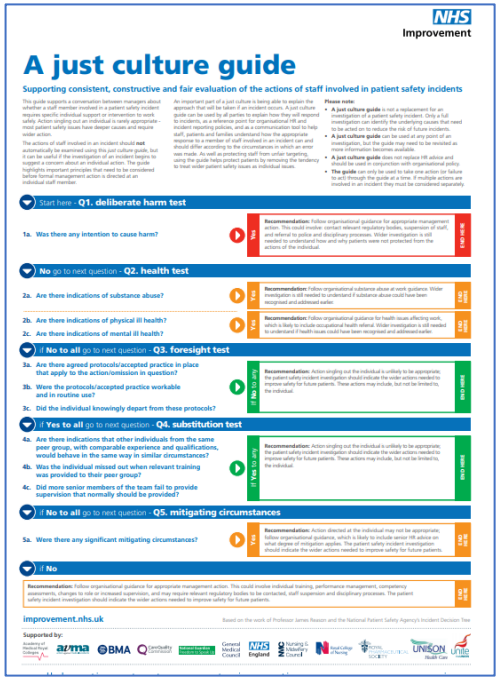
THERE ARE KNOWN KNOWNS
THERE ARE THINGS THAT WE KNOW THAT WE KNOW, THERE ARE
KNOWN UNKNOWNS
THAT IS TO SAY, THERE ARE
THINGS THAT WE NOW KNOW WE DON'T KNOW
UNKNOWN UNKNOWNS
THERE ARE THINGS
WE DO NOT KNOW
WE DON'T KNOW
AND EACH YEAR WE DISCOVER
A FEW MORE OF THOSE
UNKNOWN
UNKNOWNS

What else could we learn from each other at this conference about sustained changes to practice?

[One year after 'action complete' declared] NG placed….no stomach aspirate, therefore CXR requested. Reviewed by ward doctor. Verbal confirmation of correct position and feed started. Reviewed on ward round following morning, drop in oxygen saturations, increased MEWS from 6-9……. CXR showed NG tube in right main bronchus.

Doctor in question recognised error and [has had] discussion with clinical supervisor, educational supervisor informed. Advised [to undertake] training and reflection.

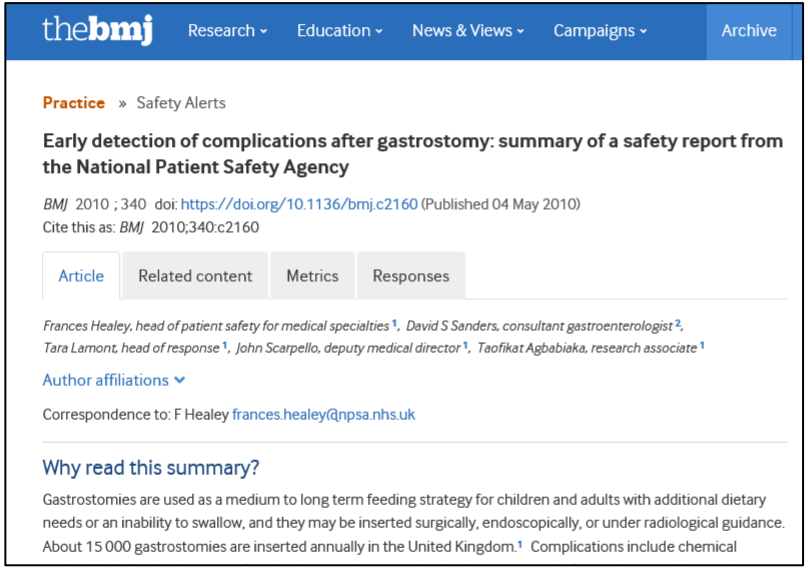
What else could we learn from each other at this conference about a delivering a just culture and recognising a need for systems improvement?


NHS Improvement

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

https://improvement.nhs.uk/resources/just-culture-guide/



thebmj Research Education News & Views Campaigns Archive

Practice » Safety Alerts

Early detection of complications after gastrostomy: summary of a safety report from the National Patient Safety Agency

BMJ 2010 ; 340 doi: https://doi.org/10.1136/bmj.c2160 (Published 04 May 2010)
Cite this as: *BMJ* 2010;340:c2160

Article | Related content | Metrics | Responses

Frances Healey, head of patient safety for medical specialties [1], David S Sanders, consultant gastroenterologist [2], Tara Lamont, head of response [1], John Scarpello, deputy medical director [1], Taofikat Agbabiaka, research associate [1]

Author affiliations

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Why read this summary?

Gastrostomies are used as a medium to long term feeding strategy for children and adults with additional dietary needs or an inability to swallow, and they may be inserted surgically, endoscopically, or under radiological guidance. About 15 000 gastrostomies are inserted annually in the United Kingdom.[1] Complications include chemical

NHS England

Patient Safety Alert

Stage One: Warning
Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder
05 February 2015

Alert reference number: NHS/PSA/W/2015/002
Alert stage: One - Warning

Dysphagia (swallowing problems) occurs in all care settings[1] and although the true incidence and prevalence are unknown, it is estimated the condition can occur in up to 30% of people aged over 65 years of age[2]. Stroke, neurodegenerative diseases and learning disabilities can be the cause of some cases of dysphagia, and may also result in cognitive or intellectual impairment, as well as visual impairment.

The modification of liquid thickness and food texture is common practice in dysphagia management to avoid aspiration of material into the airway, whilst maintaining adequate hydration and nutrition. Thickening agents are available in a range of preparations, the most common being a powdered form, supplied in tubs and commonly kept in a place that is accessible such as at the bedside.

NHS England has received details of an incident where a care home resident died following the accidental ingestion of the thickening powder that had been left within their reach. Whilst this death remains under investigation, it appears the powder formed a solid mass and caused fatal airway obstruction. Analysis of the National Reporting and Learning System has identified five other similar incident that occurred in hospital:

HCA alerted by another patient that the patient was choking. Found to have taken the lid off a tub of thickening powder and attempted to sip it back to 'drink'. The patient is partially sighted and his condition fluctuates re conscious / alert levels. Thickener was a fresh tub today as trial re his poor swallow.....

Feedback from frontline staff indicates that the potential consequences of trying to swallow dry thickening powder appear under-recognised therefore there may be significant under reporting.

Whilst it is important that produ... to be aware of potential risks to ... administration of thickening pow... voider context of protocols, beds ... and access to expert advice requ... care of individuals with dysphag... planning is required to ensure th... protected.

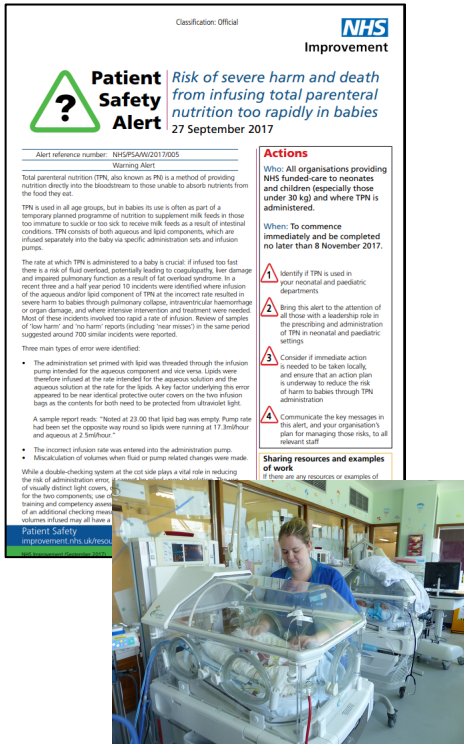
Actions

Who: All providers of NHS funded care where thickening agents are prescribed, dispensed or administered

When: To commence immediately and be completed by no later than 19 March 2015

1. Identify if the accidental ingestion of dry thickening powder has occurred, or could occur, in your organisation
2. Consider if immediate action needs to be taken locally, and ensure that an action plan is underway if required, to reduce the risk of further incidents occurring.
3. Distribute this alert to all relevant staff who care for children or adults in primary care, emergency care, and inpatient care settings, including mental health and learning disability units.

Patient Safety | Domain...
www.england.nhs.uk/pa...



Classification: Official

NHS Improvement

Patient Safety Alert

Risk of severe harm and death from infusing total parenteral nutrition too rapidly in babies
27 September 2017

Alert reference number: NHS/PSA/W/2017/005
Warning Alert

Total parenteral nutrition (TPN), also known as PN) is a method of providing nutrition directly into the bloodstream to those unable to absorb nutrients from the food they eat.

TPN is used in all age groups, but in babies its use is often as part of a temporary planned programme of nutrition to supplement milk feeds in those too immature to suckle or too sick to receive milk feeds as a result of intestinal conditions. TPN consists of both aqueous and lipid components, which are infused separately into the baby via specific administration sets and infusion pumps.

The rate at which TPN is administered to a baby is crucial: if infused too fast there is a risk of fluid overload, potentially leading to coagulopathy, liver damage and impaired pulmonary function as a result of fat overload syndrome. In a recent three and a half year period 10 incidents were identified where infusion of the aqueous and/or lipid component of TPN at the incorrect rate resulted in severe harm to babies through pulmonary collapse, intraventricular haemorrhage or organ damage, and where intensive intervention and treatment were needed. Most of these incidents involved too rapid a rate of infusion. Review of samples of 'low harm' and 'no harm' reports (including 'near misses') in the same period suggested around 700 similar incidents were reported.

Three main types of error were identified:

- The administration set primed with lipid was threaded through the infusion pump intended for the aqueous component and vice versa. Lipids were therefore infused at the rate intended for the aqueous solution and the aqueous solution at the rate for the lipids. A key factor underlying this error appeared to be near identical protective outer covers on the two infusion bags as the contents for both need to be protected from ultraviolet light.

  A sample report reads: "Noted at 23.00 that lipid bag was empty. Pump rate had been set the opposite way round so lipids were running at 17.3ml/hour and aqueous at 2.5ml/hour."

- The incorrect infusion rate was entered into the administration pump.
- Miscalculation of volumes when fluid or pump related changes were made.

While a double-checking system at the cot side plays a vital role in reducing the risk of administration error, [illegible] of visually distinct light covers, ... for the two components, use of ... training and competency assess... of an additional checking mea... volumes infused may all have a ...

Actions

Who: All organisations providing NHS funded-care to neonates and children (especially those under 30 kg) and where TPN is administered.

When: To commence immediately and be completed no later than 8 November 2017.

1. Identify if TPN is used in your neonatal and paediatric departments
2. Bring this alert to the attention of all those with a leadership role in the prescribing and administration of TPN in neonatal and paediatric settings
3. Consider if immediate action is needed to be taken locally, and ensure that an action plan is underway to reduce the risk of harm to babies through TPN administration
4. Communicate the key messages in this alert, and your organisation's plan for managing those risks, to all relevant staff

Sharing resources and examples of work

If there are any resources or examples of

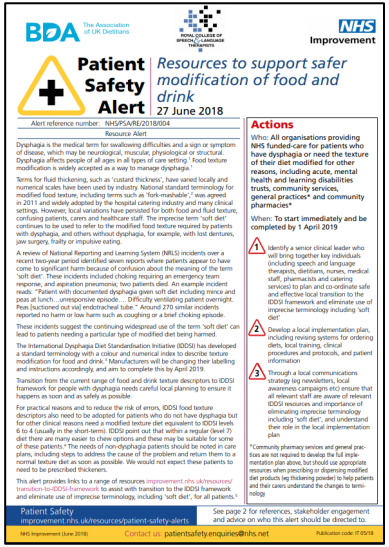
Patient Safety
improvement.nhs.uk/resou...

What else could we learn from each other at this conference about preventing and managing the rarer risks?

‘Soft diet’

IDDSI
International Dysphagia Diet Standardisation Initiative
www.iddsi.org

NHS



BDA The Association of UK Dietitians
Royal College of Speech & Language Therapists
NHS Improvement

Patient Safety Alert

Resources to support safer modification of food and drink

27 June 2018

Alert reference number: NHS/PSA/RE/2018/004

Resource Alert

Dysphagia is the medical term for swallowing difficulties and a sign or symptom of disease, which may be neurological, muscular, physiological or structural. Dysphagia affects people of all ages in all types of care setting.[1] Food texture modification is widely accepted as a way to manage dysphagia.[2]

Terms for fluid thickening, such as ‘custard thickness’, have varied locally and numerical scales have been used by industry. National standard terminology for modified food texture, including terms such as ‘fork-mashable’,[3] was agreed in 2011 and widely adopted by the hospital catering industry and many clinical settings. However, local variations have persisted for both food and fluid texture, confusing patients, carers and healthcare staff. The imprecise term ‘soft diet’ continues to be used to refer to the modified food texture required by patients with dysphagia, and others without dysphagia, for example, with lost dentures, jaw surgery, frailty or impulsive eating.

A review of National Reporting and Learning System (NRLS) incidents over a recent two-year period identified seven reports where patients appear to have come to significant harm because of confusion about the meaning of the term ‘soft diet’. These incidents included choking requiring an emergency team response, and aspiration pneumonia; two patients died. An example incident reads: “Patient with documented dysphagia given soft diet including mince and peas at lunch…unresponsive episode… Difficulty ventilating patient overnight. Peas [suctioned out via] endotracheal tube.” Around 270 similar incidents reported no harm or low harm such as coughing or a brief choking episode.

These incidents suggest the continuing widespread use of the term ‘soft diet’ can lead to patients needing a particular type of modified diet being harmed.

The International Dysphagia Diet Standardisation Initiative (IDDSI) has developed a standard terminology with a colour and numerical index to describe texture modification for food and drink.[4] Manufacturers will be changing their labelling and instructions accordingly, and aim to complete this by April 2019.

Transition from the current range of food and drink texture descriptors to IDDSI framework for people with dysphagia needs careful local planning to ensure it happens as soon and as safely as possible.

For practical reasons and to reduce the risk of errors, IDDSI food texture descriptors also need to be adopted for patients who do not have dysphagia but for other clinical reasons need a modified texture diet equivalent to IDDSI levels 6 to 4 (usually in the short-term). IDDSI point out that within a regular (level 7) diet there are many easier to chew options and these may be suitable for some of these patients.* The needs of non-dysphagia patients should be noted in care plans, including steps to address the cause of the problem and return them to a normal texture diet as soon as possible. We would not expect these patients to need to be prescribed thickeners.

This alert provides links to a range of resources improvement.nhs.uk/resources/transition-to-IDDSI-framework to assist with transition to the IDDSI framework and eliminate use of imprecise terminology, including ‘soft diet’, for all patients.*

Actions

Who: All organisations providing NHS funded-care for patients who have dysphagia or need the texture of their diet modified for other reasons, including acute, mental health and learning disabilities trusts, community services, general practices* and community pharmacies*

When: To start immediately and be completed by 1 April 2019

1. Identify a senior clinical leader who will bring together key individuals (including speech and language therapists, dietitians, nurses, medical staff, pharmacists and catering services) to plan and co-ordinate safe and effective local transition to the IDDSI framework and eliminate use of imprecise terminology including ‘soft diet’
2. Develop a local implementation plan, including revising systems for ordering diets, local training, clinical procedures and protocols, and patient information
3. Through a local communications strategy (eg newsletters, local awareness campaigns etc) ensure that all relevant staff are aware of relevant IDDSI resources and importance of eliminating imprecise terminology including ‘soft diet’, and understand their role in the local implementation plan

*Community pharmacy services and general practices are not required to develop the full implementation plan above, but should use appropriate resources when prescribing or dispensing modified diet products (eg thickening powder) to help patients and their carers understand the changes to terminology

Patient Safety improvement.nhs.uk/resources/patient-safety-alerts

See page 2 for references, stakeholder engagement and advice on who this alert should be directed to.

NHS Improvement (June 2018) Contact us: patientsafety.enquiries@nhs.net Publication code: IT 05/18

What else could we learn from each other at this conference about the ‘translation gap’ between expert and everyday understanding?

https://improvement.nhs.uk/news-alerts/safer-modification-of-food-and-fluid/

Pret allergy labelling ‘inadequate’, baguette death inquest finds

28 September 2018 Share

Pret allergy death

Allergic teenager who died was misled about Byron burger – coroner

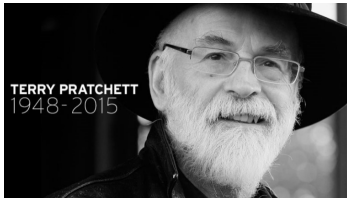
Owen Carey, 18, told London restaurant staff of his dairy allergy, inquest finds

▲ Owen Carey suffered a fatal reaction after eating grilled chicken coated in buttermilk. Photograph: Family handout/PA

The family of a teenager who died of an allergic reaction to an unlisted ingredient in a burger have called for a new law on allergen labelling in restaurants.

What else could we learn from each other at this conference about how other industries manage allergens in food?

“There have been times, lately, when I dearly wished that I could change the past. Well, I can’t, but I can change the present, so that when it becomes the past it will turn out to be a past worth having.”



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