## X-ray confirmation of nasogastric tube placement: documentation in patient notes

## Descriptor

Audit compliance with NPSA patient safety alert:2011/PSA002 - reducing harm caused by misplaced nasogastric tubes [1].

## Background

Nasogastric tube feeding is common practice and thousands of tubes are inserted daily without incident. Feeding into the lung, through a misplaced nasogastric tube is now a "Never Event" in England. "Never Event" reports to National Patient Safety Agency (NPSA) suggests there are issues with x-ray interpretation [2]. This audit assesses the documentation required after second line x-ray confirmation of tube placement following initial insertion prior to commencement of usage for feeding.

## The Cycle

### The Standard

Interpretation of chest x-rays performed to establish position of nasogastric tube for the purpose of feeding must be documented in patient’s notes.

• Is there documentation in the notes?

• Grade of the interpreter who confirmed the position of the nasogastric tube

• Confirmation that the x-ray was the most current x-ray for the correct patient

• Clear instructions as to required actions eg. safe for feeding [1]

### Target

100%

## Assess local practice

### Indicators

Percentage of chest x-rays performed to establish position of nasogastric tube for purpose of feeding with recorded interpretation in patient’s notes.

### Data items to be collected

• Prospective study: clinical notes for all patients who had chest x-rays performed to establish position of nasogastric tube for purpose of feeding

• • Date and time relevant x-ray reviewed/ documented in clinical notes

• Confirmation that the x-ray report viewed was the current for the patient

• Grade of person who confirmed position of nasogastric tube in clinical notes

### • Documentation of instructions eg. safe for feeding, unsafe for feeding or to be removed

### Suggested number

At least 40 consecutive patients with chest x-rays performed to establish position of nasogastric tube for feeding.

## Suggestions for change if target not met

• Remind nursing staff, doctors and practitioners requesting second line x-ray confirmation of nasogastric tube placement to ensure accurate documentation prior to utilisation of nasogastric tube for feeding

• Encourage utilisation of patient documentation sheet specifically for nasogastric tube bedside placement check [1]

• Repeat date for next audit (following change) in six months

## Resources

• Radiographer to log x-rays taken for nasogastric tube check

• Time for performing the hospital information system and PACS check and reviewing patient notes on a daily basis

• Audit lead to collate results and write report

• Allow eight hours for scrutinising records and preparing Formal Report.

## References

1. Patient Safety Alert NPSA/2011/PSA002: Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants; March 2011 (above).
2. National Patient Safety Agency: Never Events Annual Report 2009-2010. http://www.nrls.npsa.nhs.uk/neverevents/?entryid45=83319 [accessed 11 April 2018]

## Editors Comments

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