# 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: all chest x-rays performed to establish position of nasogastric tube for purpose of feeding

• Time and date of relevant chest x-ray correlated on PACS

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

• Grade of person who confirmed position of nasogastric tube

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

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

**Suggested number:**

At least 40 consecutive 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.

[**nasogastric\_alert\_final\_2011\_03\_09\_3.pdf**](https://www.rcr.ac.uk/sites/default/files/audit_template/nasogastric_alert_final_2011_03_09_3.pdf)PDF - 321.96 KB

**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]

**Submitted by:**

ALChang, C Keeble. Updated by AL Chang 2015 and 2018

**Published Date:**

Wednesday 28 September 2011

**Last Reviewed:**

Wednesday 11 April 2018