Patient Safety Alert

Stage One: Warning

Placement devices for nasogastric tube insertion DO NOT replace initial position checks

December 2013

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Alert stage:	One - Warning

In two recently reported patient safety incidents, enteral nutrition was unintentionally given into the respiratory tract through a misplaced nasogastric tube inserted **with the aid of a placement device**. Both the patients have since died. Two similar moderate harm incidents were reported to the National Reporting and Learning System in 2010.

An example incident report states:

Patient had a nasogastric tube inserted on the day shift with [placement device]. All was well with insertion and clearly documented. … When the night shift arrived the patient started regurgitating, the feed was switched off, and when the patient was suctioned it seemed there was feed coming up from the lungs. About 200mls was aspirated. An x-ray was done which showed the tube to be in the left bronchus.

There have been no reported issues with the functioning of these placement devices which, when used in accordance with manufacturer's instructions, may help reduce the risk of tube misplacement compared to traditional unguided insertion. However, it is vital that even when using such placement devices, staff also continue to adhere to previous National Patient Safety Agency (NPSA) guidance and perform pH or x-ray testing to confirm gastric placement after initial insertion.

The NPSA Alert *Reducing the harm caused by misplaced nasogastric tubes in adults, children and infants (2011)* stated that a **pH of 1 to 5.5 or an x-ray are the only acceptable methods for confirming initial placement of a nasogastric tube**.

This Alert and a later *Rapid Response Report (2012)* also emphasised the importance of ensuring all possible steps are taken to reduce the likelihood of human error, including competency-based training for staff interpreting x-rays or testing the pH of aspirate, using CE marked pH paper intended for gastric secretions, and never inserting any substance down the tube (including lubricant to aid guide wire removal) prior to confirming initial placement. **This advice still stands**, even when placement devices are used.

If appropriate, NHS England will issue further advice when investigation of these recent incidents is complete. We will continue to work with all manufacturers of nasogastric tube placement devices to ensure their guidance is compatible with national safety advice. Nasogastric tube placement devices can continue to be used in accordance with manufacturers' instructions AND the placement confirmation checks required by national guidance.

Actions

Who: All hospitals and community services that insert nasogastric tubes

When: As soon as possible but no later than 8 January 2014

1. Establish if placement devices are used within your organisation to aid nasogastric tube placement, and if similar incidents have occurred.
2. Consider if any action needs to be taken locally to reduce the risk of a similar incident occurring, including ensuring earlier NPSA advice is fully and consistently implemented.
3. If your organisation uses placement devices for nasogastric tube placement, share this Alert with all nursing, medical and therapy staff.[1]
4. Share any learning from local investigations or locally developed good practice resources with the national Patient Safety Team via patientsafety.enquiries@nhs.net.

Supporting information

For more detailed information to support the implementation of this guidance go to www.nrls.npsa.nhs.uk/resources

[1] *Organisations that do not use placement devices do not need to distribute this Alert to frontline staff, but should share it with all staff likely to be involved in decisions to introduce nasogastric tube placement devices.*

Publications Gateway Reference 00876