

Nasogastric tubes in the Community

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Case study

- Ellie
- Age 58
- Married.
- 3 grown up children

- Bulbar on set MND
- Diagnosed 18/09/2023
- Strong limb function
- Very poor bulbar function



Admission to Neuro Ward

- Admitted to ward pre-PEG.
- Very weak
- Not eaten for 4 days
- No fluids for 3 days
- Constipated
- Bloods
- IV fluids
- NG tube placed
- Discussion about wishes and ceilings of care.
- Husband worried about managing a feeding tube.
- He was stressed and not coping well

Complications

- PEG placement tried and failed due to a high riding stomach
- CT Scan suggested RIG may be possible
- RIG placement failed
- Discussed options



Going home with an NG tube - not an option

- Community staff not taking responsibility
- Need a Risk assessment
- Care plan
- Shared care protocols in Oxfordshire
- NG feeds level 5!
- Family would normally be asked if they would care for the tube and do the feeds.
- Ellie felt that this was not an option
- Her husband would not be able to manage the tube.
- Children not local

- Conversation about how she will die if she can't eat.
- Talked about palliative care



One last try!

- Surgical PEG was successful
We have never done this before



National Patient Safety Agency (2019)

misplaced naso or orogastric tube not detected prior to use

3 million NG tubes placed in the UK in 2019

- 200,000 incidence recorded
- 20 were Never Events

- A Never Event is....

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.'

National Patient Safety Agency (NPSA) Sept 2005 – March 2010

Checking method where error occurred	Number of incidents reported	Number of deaths
X-ray misinterpretation	45	12
Fed despite aspirate tested pH 6-8 *	7	2
Fed after apparently obtaining pH 1 – 5.5	9	1
Water instilled down nasogastric tube before testing pH *	2	0
Not checked at all *	9	1
Apparent migration after initially correct placement (e.g. after suction)	8	1
No information obtained on checking method used *	17	4
Placed under endoscopic guidance	1	0
Visual appearance of aspirate *	1	0
Bubble test *	1	0
Totals	100	21

pH checking & documentation

- pH testing is used as the first line test method,
- pH between 1 and 5.5 is the safe range,
- Each test and test result should be documented on a chart kept at the patient's bedside
- Documentation following pH testing should include:
 - whether aspirate was obtained
 - what the aspirate pH was
 - who checked the aspirate pH
 - when it was confirmed to be safe to administer feed and/or medication (i.e. gastric pH between 1 and 5.5)

What are the risks of an NG tube in the community?

“ not common but has its place if managed correctly. It can be a means to providing nutrition in the community”

- Most incidents occurred in hospital
- X-rays mis read
- Not tested correctly

Best C (2013) Nasogastric feeding in the Community:
Safe and effective practice. BJCN

National Patient Safety Agency (2009)

Can NG tubes be used in the community?

- A full multidisciplinary supported risk assessment should be made and documented, before a patient with a nasogastric tube is discharged from acute care to the community

What are the potential
Risks?

Risks and Care plan.

- Tube misplaced
- Tube falling out
- Sore around nose
- Not having supplies
- Using the wrong syringe
- Misinterpreting pH
- Not doing pH
- Using litmus paper

Training –

- Who will care for it?
- What happens if it falls out
- Use of suction machine

5 steps of creating a risk assessment?

The Health and Safety Executive's Five steps to risk assessment.

- Step 1: Identify the hazards.
- Step 2: Decide who might be harmed and how.
- Step 3: Evaluate the risks and decide on precautions.
- Step 4: Record your findings and implement them.
- Step 5: Review your risk assessment and update if necessary.

Hazard	People Affected	Level of risk High Medium Low	Existing Measures	Additional Measures

References

National Patient Safety Agency: Reducing harm caused by the misplacement of nasogastric feeding tubes; Patient Safety Alert 05; Feb. 05. Available online at: www.nrls.npsa.nhs.uk/resources/?EntryId45=59794 2. National Patient Safety Agency.

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