Naso-Gastric Feeding

Theme | Learning from Incidents

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SaTH Improvement Hub

NHS The Shrewsbury and Telford Hospital NHS Trust

REASON WHY?

Following an SI where an NG tube was wrongly inserted a new training program has been developed and rolled out to all people who would insert NG tubes. During the training feedback was received that often people could not find the equipment that they needed to complete the task and did not complete the correct paperwork because they did not have time to find it and print it off

SMART AIM

S SPECIFIC M MEASUREABLE A ACHIEVABLE R RELEVANT T TIME-BOUND

To reduce the amount of time taken to collect the equipment needed to place a NG tube and to increase the availability of the correct paperwork by September 2023

PLAN

The plan was to visit each ward at RSH and PRH and ascertain where the Naso- Gastric feeding tube equipment was stored with a view to making sure everything that was needed would be in the same place.

Secondly to ensure that the equipment was accompanied by a laminated Standard operating procedure (SOP) that includes the Naso-Gastric Feeding tube insertion procedure (from the policy) which tells staff what equipment is needed, how to measure insertion length and how to check it is in the correct place. It also includes contraindications and the documentation that staff need complete after they have completed the procedure.

This is currently only available on the Intranet and not in print format.

DO

Initially there was a visit to every inpatient ward at PRH to find out where their equipment was kept, followed by a visit to deliver the SOP. Discussions were held with either the ward manager or sister on every ward, if they were not available the most senior nurse on the ward was spoken to. These discussions were regarding the placement of the SOP next to or with the equipment.

Then at RSH the majority of wards were visited and then emails sent to ward managers and matrons (at both sites) also emails sent to the Practice Education Facilitators (PEF's).

STUDY

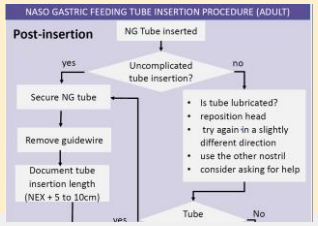
The stock room on 25C

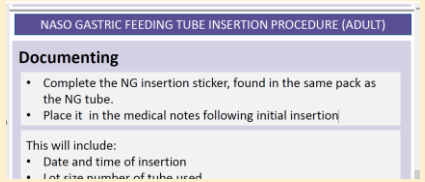
The expectation was that the equipment would be not together or stored in the kitchen, however fears of stock being spread out and being unobtainable to staff were therefore unfounded.

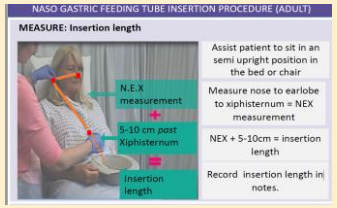
At RSH the wards audited use a central stock which is based on ward 25C. All the stock is kept together apart from the pH strips which are available on request. The wards at RSH do not often perform this procedure and therefore a central accessible point works for all places audited. Wards that did have a stock of their own (AMU for example) kept the equipment together and in the clean utility.

At PRH it was found that all wards used the clean utility to keep stock and all the correct equipment was kept together.

The SOP was distributed in person, with discussions held with staff in 22 adult inpatient wards across both sites. (Women's and Children's service were not included as the SOP is about adult feeding) . The remaining wards were sent the SOP via email with information regarding its use, and its placement.







ACT

ADOPT

Regarding the placement of the equipment no changes were necessary and therefore no one was measured in terms of the time taken to collect equipment. Everyone at RSH knew where the stock was held.

ADAPT

The ward at RSH has added a sign regarding the location of PH strips in order to improve people being able to access them.

Next Steps:

All the SOPS are currently in place on the wards at PRH, relevant wards at RSH and in the central stock cupboard on 25C. There will need to be a follow-on audit to check they are still in place early in the new year.

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