The NHS uses at least 27,000 naso-gastric tubes annually and the vast majority produce benefit to the patient in terms of improved nutrition and safe administration of medication. However, there is a small but significant risk of harm if the tube is not placed properly in the stomach or if subsequently it becomes displaced and this is not recognised. In recent years aspiration of the tube and checking for a pH of <5.5 has been increasingly performed to ensure correct placement but where it is not possible to obtain an acid pH then a chest x-ray is requested to check to see if the tube is in the stomach. Training is required to ensure interpretation of the x-ray is done safely and systematically.

In recent years the main reason for harm from naso-gastric tube misplacement has been through misinterpretation of x-rays as reported by the NPSA in 2005 and subsequently in 2011. There were at least 45 instances, 12 of which resulted in the death of the patient and so this is of crucial importance. Severe harm or death due to a misplacement of an NG tube is a Never Event and serious incident investigations have recurrently shown that misinterpretation of the chest x-ray is part of the problem.

A training package is available on the learning hub to take all doctors through safe x-ray interpretation of naso-gastric tubes and the correct method to utilise when checking an x-ray. This training only needs to be completed once, doctors will then be able to self-certify that they are competent and will be able to add this to their learning portfolio.

To access the training please follow this link to the Learning HUB https://learninghub.yorkhospitals.nhs.uk/course/view.php?id=1441

If you have any queries please contact Diane Palmer, Deputy Director of Patient Safety or Dr Peter Wanklyn