“See the big picture and stay vigilant over patient safety”

In 2004, a child died after being fed through a nasogastric tube that had been misplaced in her lungs. The nurses were devastated by their involvement in the circumstances that led to her death.

Her death and the deaths of 10 other patients in similar circumstances led to the National Patient Safety Agency (NPSA) issuing its first alert on reducing harm caused by misplaced NG tubes in 2005. But similar deaths continued to be reported, leading to a further alert in 2011 and a rapid response report (RRR) in 2012 (all can be found at tinyurl.com/NPSA-alerts).

There are lessons to be learnt from this that go beyond NG tube feeding and can be applied more widely to nurses’ involvement in patient safety, such as the topic of dysphagia management covered in this issue (page 12).

At the time of the NPSA’s initial alert in 2005, the key patient safety problem was inconsistency in local policies for checking NG tube placement before starting feeding. Research papers had been published that showed the “whoosh test” and litmus paper were not reliable, and a number of organisations had moved to pH paper and X-ray checking instead. But some local policies still recommended methods of confirming placement that were long discredited.

Could this still happen in your organisation? Is there more that you can do to ensure that the review of every policy and protocol is thorough and comprehensive?

In the years that followed, the importance of a local leader who oversees implementation of guidance became clear. Do you have similar champions to coordinate all other areas of patient safety?

By the time we issued our 2011 alert, the main source of error was misinterpretation of X-rays, sometimes by senior and experienced doctors who had been busy and distracted, and sometimes by junior doctors who did not have the knowledge and skills to do this.

Yet nurses have a part to play too – how often do we ask a doctor in the middle of one task to just take a look at something else, or check they are confident and competent to do whatever needs to be done?

The two deaths that led to our most recent RRR involved injecting a small amount of water down NG tubes before initial confirmation of stomach placement, leading to false pH readings. It appeared that skilled and experienced nurses no longer referred to the local protocol or the manufacturer’s instructions – which prohibited this – and had developed their own unwritten ways of doing things. Are there other areas where you know policy and practice have become dangerously separated?

The two patients who died would have been three but for one nurse who “had a feeling something wasn’t right” with the pH result. Nurses’ intuition – which is not a psychic power but the subconscious application of knowledge and experience – can help you step up to protect your patients. So remember the positive difference nurses can make.

Frances Healey is associate director of patient safety at the National Patient Safety Agency

Ann Shuttleworth is practice and learning editor of Nursing Times.

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