Radiographer-led Naso-gastric (NG) Tube service
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**Aims**
- Every patient for chest X-ray (CXR) for NG positioning to return to the ward with a correctly placed NG tube, with an official report and ready to be fed
- Reduce the need for patients to return to radiology for further imaging after manipulation of misplaced NG tubes

**Why did we change the service?**
- Improve patient experience
- Comply to 2005 & 2011 NPSA safety alerts for harm caused by feeding through a misplaced NG feeding tube
- Reduce the likelihood of a Never Event

**What did we do?**
- Trained 4 radiographers to report CXRs for NG tube position
- Taught the same radiographers to insert &/or manipulate NG tubes into a position safe for feeding

**Outcome of 205 NG tubes following radiographer reports of CXR**
- 80% NG correct position
- 10% NG advanced
- 2% NG withdrawn
- 1% NG coiled
- 5% NG new
- 2% NG removed

**Number of visits to radiology for check NG position on CXR**

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<th>Before NG service change (May 2014 - April 2015)</th>
<th>Post NG service change (August 2017 - July 2017)</th>
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**Conclusion**
- 20% patients arrived in radiology with an NG incorrectly sited NG tube. They were returned to ward with their tube in a safer position for feeding.
- 21% reduction in patient transfers to radiology

**References**