

Invasive Procedure Safety Checklist: NG TUBE INSERTION

BEFORE THE PROCEDURE

Patient identity checked as correct? Yes No

Appropriate consent completed? Yes No

NEX measurement (cms) Yes No

Are there any Contraindications to performing the procedure?
(Coagulopathy/base of skull#/previous sphenoidal surgery) Yes No

Are there any concerns about this procedure for the patient? Yes No

Names/Registering body numbers of clinicians responsible for NG tube insertion

1) _____

2) _____

3) _____

TIME OUT

Verbal confirmation between team members before start of procedure

Base of skull # ruled out if applicable? Yes No

Is position optimal? Yes No

All team members identified and roles assigned? Yes No

Any concerns about procedure? Yes No

If you had any concerns about the procedure, how were these mitigated?

SIGN OUT

Any equipment issues? Yes No

Is a chest X-ray required? Yes No

Is aspirate below pH 5.5? Yes No

Post procedure hand over given to nursing staff? Yes No

Signature of responsible clinician completing the form

Patient Identity Sticker:

Procedure date: Time:

Operator:

Observer:

Assistant:

Level of supervision: SpR Consultant

Equipment & trolley prepared: