

Quality improvement Activity: Tube Feeding Safety Protocol

Describe the Scenario

An 18-month-old child was admitted to the hospital with a history of bile obstruction. The child was transferred from a nearby town. The family sought medical treatment because the child was cranky and was not holding down food. Initially a NG tube was placed to release air from the patient's stomach. During this time the child was being feed by mouth. As time progressed and the child begin tolerating the feeding the NG tube was removed. Shortly after the removal of the tube, the child begins to vomit after meals, so the NG tube was placed back into the patients nose, this time the tube was also used for feedings. After one feed the child begin to vomit. Following the vomiting episode, the NG tube was assessed for placement, the tube was advanced, to the previous measurement. The tube was not checked to ensure proper placement, with an Xray, air, or PH paper. The nurse should have followed up with an Xray or a pH paper check. After the tube was advanced to the correct length, the tube was used again. While working on the children's unit I have seen a tube be replaced several times without being adequately checked for placement, before continuing use.

In what way did the patient care and environment lack? Is this common occurrence?

The healthcare team lacked by not ensuring placement of the tube by additional means other than just the measurement of the tube. This occurs frequently on the unit. I've witnessed nurses asking more tenured nurses if they should do additional checks and it is declined.

What Circumstances Led to the occurrence

When a tube comes out many times it is frustrating for the nurse.

The nurse becomes frustrated because inserting a tube into a child can be traumatizing to the child. During this incident the nurse was frustrated, and did not fully agree with the doctor about keeping the tube in. Frustration, avoidance, and a lack of knowledge led up to the occurrence

In what way could you measure the frequency of the occurrence?

The frequency of the occurrence of misplaced tubes is not a priority for the facility currently. By priority I mean there is not a lot of ongoing education, reminders, and tracking currently. The frequency could be measured by interviewing the nurses and asking them the protocol, and when is it appropriate not to follow the protocol. Also, there could be an anonymous reporting line, that keeps the reporter and the person not following the protocol anonymous. Also creating a detailed charting section for tubes. Additionally, ongoing training.

What evidence-based ideas do you have for implementing interventions to address the problem?

A detailed charting section for the protocol, if nurses have to document what they did or did not do in detail they are more likely, to do all of the steps needed. It also serves as a reminder of what should be done. Tracking the bad outcomes and sharing them with the unit. Ongoing teaching and learning.

How will you measure the efficacy of the intervention?

To measure the efficacy, I would compare the numbers from before to the current numbers of incidents. Also ask the staff, about their opinions on the intervention. I would also share this data with the staff.