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: ____________________