**INVASIVE PROCEDURE SAFETY CHECKLIST: NG Tube Insertion**

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| --- | --- | --- |
| **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 and registering body numbers of clinicians responsible for the procedure | | |
| 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? | | |
|  | | |

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| --- | --- | --- |
| **Procedure date:** |  | |
| **Time:** |  | |
| **Operator:** |  | |
| **Observer:** |  | |
| **Assistant:** |  | |
| **Level of supervision:** | SpR | Consultant |
| **Equipment & trolley prepared:** |  | |

|  |  |  |
| --- | --- | --- |
| **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:**

