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31 July 2009

Dear

**Freedom of Information Act request: Misplaced Nasogastric Tubes**

I am writing in response to your email request dated 14 July 2009, which has been dealt with as a request for information under the FOI Act. Thank you for your enquiry.

You have requested for information about "...incidents involving xray misinterpretation to see how often this occurred as a fraction of all the total incidents and those incidents together with the outcome in these particular incidents,(survival vs death)."

We have recently carried out an analysis covering a one year period, 1<sup>st</sup> March 2008 to 28<sup>th</sup> February 2009 on incident reports involving misplaced nasogastric tubes. A search of the Reporting and Learning System (RLS) was conducted using key terms relating to nasogastric tubes. This search returned 494 reports. A clinical review of these reports found that:

- 21 incident reports were identified as relevant to the topic of nasogastric tube misplacement
- 8 of these 21 were identified as involving misinterpretation of xrays.

The table below shows a breakdown of the 8 incidents by the reported degree of harm:

<b>Degree of Harm Summary:</b>	Degree Of Harm	Number of Incidents
	No Harm	2
	Low Harm	1
	Moderate	3
	Severe	2
	<b>Total</b>	<b>8</b>

The RLS is designed as a staff based reporting system; therefore all the incidents reported above were submitted by NHS staff.

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It is important to note that as incidents are self-reported to the NPSA on a voluntary basis, the results described above are not necessarily representative of the NHS across England and Wales and should not in any way be regarded as a national total.

### **Degree of harm to patient**

The reporting of degree of harm in the RLS is intended to be the actual degree of harm suffered by the patient. However due to large number of organisations/people reporting to the RLS this is not always the case:

- Confusing the potential degree of harm of an incident with actual degree of harm that occurred, for example coding near misses (where no harm resulted) as 'severe' harm. The NPSA requires the degree of harm to reflect the actual and not the potential degree of harm caused by the patient safety incident.
- Coding the degree of harm as 'severe' when the patient is expected to suffer severe but transient harm (for example severe bruising) instead of the required significant permanent harm (for example amputation, brain damage). An analysis of free text suggests that only about 25 per cent of incidents reported as leading to severe harm were correctly coded by the reporting organisation, as defined by the NPSA.

I hope that this information is helpful to you. If you need any further information, please do not hesitate to contact the team at [datarequestteam@npsa.nhs.uk](mailto:datarequestteam@npsa.nhs.uk)

If you are unhappy about the way in which your request has been handled, the NPSA has an internal complaints procedure through which you can raise any concerns. Further details of this procedure may be obtained by contacting the Complaints Manager. If you are dissatisfied with the outcome of the complaints procedure, you can apply to the Information Commission, who will consider whether we as a public authority have complied with its obligations under the Act, and can require NPSA to remedy any problems. You can find out more about how to do this, and about the Act in general, on their website [www.ico.gov.uk](http://www.ico.gov.uk). Complaints should be sent to:

FOI Complaints Resolution -Information Commissioner's Office  
Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF.

Yours faithfully



Dr Kevin Cleary  
Medical Director  
NPSA