NGPOD*



ARE YOU A GUIDING LIGHT IN PATIENT SAFETY?

www.ngpodglobal.com

NG Tube Misplacement



2-4% of all tubes are misplaced in

172 'Never Events' associated with NG tube misplacement since 2009



up to 45% attempts to aspirate fail¹

the respiratory tract¹

45% Never Events caused by X-Ray misinterpretation³

6 Patient safety alerts + reports since 2005



Two Patient Safety Alerts (PSA) on "Reducing the harm caused by misplaced nasogastric tubes" released⁴

Third Patient Safety Alert released after further cases of death (29) & serious harm (79)⁵

2005



2011



NG Tube 'Never Events'



Reaffirmed pH testing & x-ray as only methods of testing following use of electromagnetic device resulted in harm to patients⁷

BAPEN's NGSIG Position Paper"Time to Put Patient Safety First"

2013



2019



Use of misplaced NG Tube added to NHS 'Never Event' list



2012

Rapid Response Alert (RRR)⁶



2016

Required assessment of healthcare providers compliance with NPSA/NHSI PSA's 8

Health Safety Investigation Branch (HSIB) report "Investigation into the placement of nasogastric tubes"

pH testing is used as the first line test method, with pH between 1 and 5.5 as the safe range 5

NGPOD® pH test vs pH strip testing

p	H testing with pH strips	pH testing with NGPOD®
Requires aspirate?	YES	NO
Requires additional equipment?	YES	NO
% of tests where result is obtained	54.3%¹ - 83.9%⁵	93.5%°
Requires interpretation?	YES	NO
% Tests where result is clear	68%¹ 100%³	
Prone to human factor errors?	YES	NO
% patients requiring x-ray	31%° - 45.7%¹	24.5% ⁹

From every 100 tests using pH strips, only 37 may result in a clear outcome...

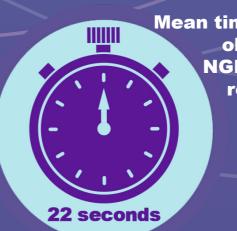
Comparing NGPOD® pH test to current NHS Trust practice for confirming the correct placement of a nasogastric (NG) tube

NGPOD® Clinical Trial IRAS number 217641, ISRCTN14985496









Mean time to obtain **NGPOD®** result



than testing with pH strips¹⁰

The NGPOD® System

NGPOD

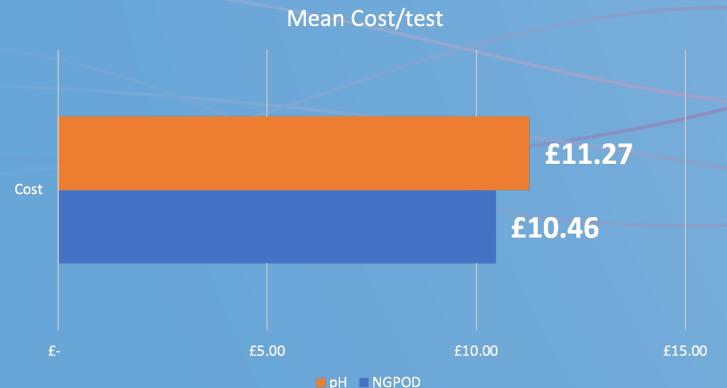
NGPOD® handheld device

- Rapid result [c.15 seconds]
- Handheld "bed side" test
- Simple to learn and operate
- **Simple interpretation [YES/NO result]**









pH indicator tipped fibre-optic sensor

- No aspiration required
- Reduced requirement for x-ray
- Compatible with NG Tube +/> 6Fr
- **Works with all brands of NG Tubes**



Patient receives hydration, nutrition & medication without delay



educing anxiety & unnecessary x-ray



STEP 1:

Turn on the NGPOD® handheld device

Observe the automatic start up self-test procedurere

(RED-AMBER-GREEN)



The device enters pre-test mode

STEP 2:

Keep Sensor in packaging, open in the corner and connect the handheld device to the Sensor connector

Both components perform an automatic pre-test sensor check, amber LED will be flashing 3 times followed by a red LED





If Green LED illuminates when Sensor is connected, device is ready to be used

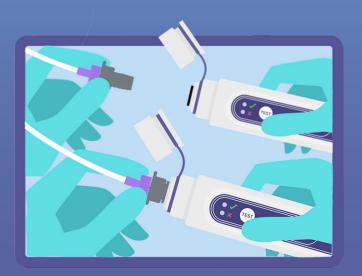
STEP 3:

Insert Sensor down NG tube



STEP 4:

Connect the Sensor to the handheld device

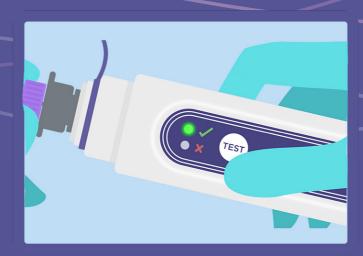


STEP 5:

Press the TEST button



Green tick indicates that sensor is in an acidic environment pH ≤ 5.5



Red cross indicates sensor is not in acidic environment or pH > 5.5



STEP 6:

Dispose Sensor in clinical waste





The NGPOD® is available to purchase now.

Contact our customer support team today:

\(+44 (0)161 696 6400 \)



Order Codes

	Direct Code	NHSSC Code	Unit of Sale
NGPOD® Handheld Device	NGPOD-01	FWM4155	1
pH Fibre-Optic Sensor - 92cm	NGPODSensor01-092	FWM4157	25

References

- 1. Borsci S, Buckle P, Huddy J, Alaestante Z, Ni Z, Hanna GB (2017) Usability study of pH strips for nasogastric tube placement. PLoS ONE 12(11): e0189013.
- 2. National Patient Safety Agency. Patient Safety Alert 05. Reducing the harm caused by misplaced nasogastric feeding tubes. 21 March 2005
- 3. NHS Improvement. Resource set Initial placement checks for nasogastric and orogastric tubes. July 2016 19
- 4. National Patient Safety Agency. Patient Safety Alert 09. Reducing the harm caused by misplaced nasogastric and orogastric feeding tubes in babies under the care of neonatal units. 18 August 2005
- National Patient Safety Agency. Patient Safety Alert NPSA/2011/PSA002 Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants. 10 March 2011
- 6. NHS England. Patient Safety Alert NHS/PSA/W/2013/001. Placement devices for nasogastric tube insertion DO NOT replace initial position checks. December 2013
- 7. National Patient Safety Agency. Rapid Response Report NPSA/2012/RRR001. Harm from flushing of nasogastric tubes before confirmation of placement. 22 March 2012
- 8. NHS Improvement. Patient Safety Alert NHS/PSA/RE/2016/006. Nasogastric tube misplacement: continuing risk of death or severe harm. 22 July 2016
- 9. Data on File (Clinical Trial) NGPOD 2020
- 10. Data on File(HECON Analysis) NGPOD 2020



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