Manitoba
Health, Healthy Living and Seniors

Manitoba Health, Healthy Living & Seniors (MHHLS) supports reporting and learning from patient safety events. The focus of a patient safety review is to look closely at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Deterioration in Patient Condition Related to Incorrect Kaofeed Tube Placement

Summary:

In accordance with policy and procedure, a client's Kaofeed tube was reinserted by ward nursing staff. Following the insertion of the tube, an abdominal X-ray was obtained to confirm correct tube placement. The abdominal x-ray was reviewed by the surgeon and resident who confirmed the correct placement of the tube and instructed that feedings be resumed.

Once the feedings were re-established, the patient developed shortness of breath and chest pain. The feedings were discontinued and the physician contacted.

The feeding tube was later confirmed to be incorrectly positioned in the lung. During the night, the patient's condition deteriorated requiring admission to the Intensive Care Unit.

Keywords: Kaofeed tube, feeding tube, x-ray confirmation

Device Name *(if applicable)*: **kaofeed tube**

Drug/Name/Fluid Name: (*if applicable*): **n/a**

Type of Analysis: single event

Topic: Care Management

Findings of the Review:

- An abdominal X-ray was ordered by the surgeon to confirm the placement of the feeding tube.
- The x-ray was not interpreted correctly by the physician.
- A chest X-ray would have been more appropriate as it would have been able to rule out placement of the feeding tube in the lung.
- The current policy regarding X-ray confirmation of Kaofeed tube placement does not specify the type of X-ray to be performed.
- Previous attempts at Kaofeed tube insertion were known to be difficult on this client; previous successful placements required the aid of endoscopy. The covering surgeon was not aware of this information. When staff raised concerns with the covering surgeon regarding the previous difficulty in inserting the feeding tube, they were directed to proceed in placing the tube.

System Learning:

- Review the event emphasizing the use of a chest X-ray to confirm that the feeding tube is not placed in the lung.
- Ensure the use of an escalation procedure in cases where there is not agreement with respect to how to manage patient care.
- Identify and communicate expectations regarding methods of client handover and communication between surgeons.
- Ensure that policies regarding placement of feeding tubes require the use of a chest x-ray to confirm that the tube has not inadvertently been placed in the lung, in keeping with best practice standards.

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