INSERTION OF A NASOGASTRIC TUBE, CONFIRMATION OF CORRECT POSITION AND ONGOING CARE IN ADULTS, CHILDREN AND INFANTS (NOT NEONATES) PROCEDURE

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Documents to read alongside this Procedure

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**Supporting information**

- Procedure for passing a fine bore nasogastric feeding tube
- Procedure for confirming correct position
- Procedure for ongoing care
- Confirmation flow diagram
- Rationale for procedures
- Guidance for Community nasogastric feeding
- Nasogastric competency record
- Competency framework for passing a nasogastric feeding tube
- Daily care record for nasogastric feeding tube
1. Introduction
Nasogastric feeding is the most common method of providing artificial nutritional support in hospital. The most common risk associated with the insertion of a nasogastric tube is misplacement of the tube into the bronchus and subsequent pulmonary aspiration when enteral feeding is in progress (1). There is a small risk that the nasogastric tube can be misplaced into the lungs during insertion, or move out of the stomach at a later stage. The National Patient Safety Agency (NPSA) is aware of a number of deaths and cases of serious harm due to misplaced nasogastric feeding tubes over recent years (2). Feeding into the lung, through a misplaced nasogastric tube is now a Never Event in England and Wales.

2. Statement
The procedure has been produced to support staff in the correct insertion of a nasogastric feeding tube, confirmation of correct position and ongoing care. The procedure for insertion of a fine bore feeding tube is based on the guidelines of the British Association of Parenteral and Enteral Nutrition (3). Confirming correct positioning of nasogastric tubes is based upon recommendations of the National Nurses Nutrition Group (4) and the NPSA (2). The procedure for passing a nasogastric tube can also be used for wide bore tubes (page 12).

3. Scope
This procedure relates to the insertion and ongoing management of a nasogastric tube across all patient groups regardless of their care setting with the exception of neonates.

4. Aim
To minimise patient risk and harm caused by misplaced nasogastric feeding tubes in line with patient safety and quality.

5. Objectives
1. To standardise the procedure for passing a nasogastric tube.
2. To standardise procedure to confirm correct position of a nasogastric tube
3. To standardise the procedure for confirmation of correct tube position on initial insertion and during on-going care.

6. Competence, accountability and responsibility
All professionals undertaking this procedure should be either:
- Registered nurses
- Registered medical staff
- Student nurses under the supervision of one of the above

It is essential for the healthcare professional to have undertaken a period of supervised practice in the insertion of nasogastric feeding tubes, supervised by a recognised practitioner i.e. qualified nurse or doctor who is competent in the insertion of nasogastric feeding tubes.

The number of supervised practices required to achieve competence will be determined by the practitioner and supervisor, taking into account the practitioner’s own learning needs (minimum of 3). Evidence of competence must
be provided, a copy kept in the practitioner’s personal file and in the ward or department where the skill is practised (page 19-20). Practitioners already undertaking this procedure must have a record of their competence (page 18). The practitioner is accountable for their own practice. Evidence of continuing professional development and maintenance of competence level will be required.

Other carers - i.e. parents of children, involved in the patient’s daily care can undertake this procedure if they have been trained by a recognised practitioner e.g. qualified nurse competent in the insertion of nasogastric feeding tubes.

7. Indication
Prior to passing a nasogastric feeding tube a risk assessment is carried out, balancing the potential risks of tube insertion against the need to feed. Actions to reduce risks and the rationale must be documented by the practitioner. Placement should be delayed if there is not sufficient experienced support available to accurately place and confirm nasogastric tube placement (e.g. at night) then, unless clinically urgent, placement is delayed until that support is available. The rationale for any decisions made should be recorded in the patient's medical notes.

8. Consent
Informed verbal consent for the procedure should be sought under the guidance of the UHB Consent to Examination and Treatment Policy. Refer to the Mental Capacity Act where consent cannot be obtained. This should be documented in the medical or nursing notes where appropriate.

9. Contra-indications
The following are possible contra-indications for the insertion of a nasogastric feeding tube:

- maxillo-facial surgery, trauma or disease
- oesophageal tumours, strictures or surgery
- base of skull fracture
- unstable cervical spine
- haematological disorders

The contra-indications are not all absolute, but individual patients should be discussed with the medical team in charge of their care before a tube is passed. Some patients may require tubes placed using direct vision, endoscopic or radiological guidance.

10. Type of tube
Wide bore (≥12fg) Ryles type tubes are primarily used for gastric aspiration and decompression and are now rarely used for enteral feeding outside Critical Care. They are associated with the following complications:

- rhinitis
- pharyngitis
- oesophageal strictures
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- gastric erosions and bleeding (5)
- increased tendency for reflux (6)
- patient discomfort
- difficulty in swallowing

Wide bore (>12fg) Ryles type tubes are made from PVC and ideally should only be in situ for 7-10 days to maximise comfort and minimise harm. A risk assessment should be undertaken if required to remain in situ for longer.

Fine bore (<12fg) polyurethane tubes overcome the above problems and the tubes used in the UHB are Medicina nasogastric tubes (6fr/55cm; 8fr/75cm for children, and 8fr/85cm for adults). These tubes can be used for up to 60 days, although an individual patient risk assessment should be undertaken after 28 days. Occasionally, patients may re-pass their tube daily. A specific reusable tube is used for this.

For those patient’s whose tubes frequently block, are displaced, or in whom aspiration is persistently difficult despite following the UHB procedure, short-term Medicina tubes (5 and 8fr, 80cm) should be considered. This tube can be used for up to 28 days.

Wide bore tubes used for feeding should be changed to fine bore tubes when clinically appropriate and feed tolerance is established to maximise patient safety and comfort. The procedure for confirming correct position should be followed before the tube is used for feeding.

Fully radio-opaque tubes that have markers to enable accurate measurement, interpretation and documentation of their position must be used (2).

11. Insertion of the tube

The procedure for passing a nasogastric tube must be followed (page 11).

If the tube meets resistance and cannot be advanced further or respiratory distress is evident, the procedure must be abandoned. The patient should be reassured and referral made to a senior member of the medical team who will review the situation and determine what action is necessary. This may include referral for assistance from the nutrition team or other appropriate clinical team. Out of hours, the responsible clinical team must risk assess further attempts at insertion versus delay in provision of enteral nutrition, and any decisions documented in the medical notes.

12. Confirming tube position

The correct position of the nasogastric tube must be confirmed following insertion and documented before feeding is commenced. Nothing should be introduced down the tube before gastric placement is confirmed i.e. do not flush.

The correct position of the nasogastric tube must also be confirmed:
- before each bolus feed or after rest periods
- following vomiting, violent coughing or retching episodes
- at least once during continuous 24 hour feeding
• following evidence of tube displacement (change in external length, loose tape)
and documented before feeding is recommended.

13. Methods not recommended
Auscultation of the epigastrium or left upper quadrant whilst air is insufflated via
the tube was historically used. This method is not able to reliably predict tube
placement in the oesophagus, stomach or respiratory tract and must not be
used (8, 9, 2).

Aspiration and testing with blue litmus paper was previously used. Although
acidic gastric secretions will turn blue litmus paper pink, litmus is not sufficiently
accurate to distinguish between gastric aspirate pH ≤ 5.5, and bronchial
secretions pH > 6 and therefore must not be used (10).

14. Methods recommended following insertion
Aspiration and testing with pH indicator strips/paper is the preferred method to
confirm tube position. A pH of 5.5 or below is acceptable as indicating gastric
placement in most patients. There is evidence to suggest that a pH reading of
between 1 and 5.5, can reliably exclude pulmonary placement of the nasogastric
tube. However, a pH between 1 and 5.5 does not necessarily confirm gastric
placement of the nasogastric tube, and there is a small possibility that the tube is
sitting in the oesophagus, which carries a higher risk of aspiration NPSA (2). The
procedure for confirming correct position of a nasogastric tube must be followed
(page 11). Medication may affect gastric acidity (11) including proton pump
inhibitors, H2-antagonists and antacids, although the desired pH can usually be
obtained (12). The pH of aspirate obtained on initial placement must be
documented for future reference.

pH indicator paper used must be CE marked and intended by the manufacturer
to test human gastric aspirate (2). The pH strips used in the UHB are Merck pH
2-9, and are available from pharmacy.

Radiography is recommended following tube insertion if the procedure or
placement was difficult e.g. coughing or vomiting during the procedure.

Radiography is recommended if unable to obtain gastric aspirate or the pH is
greater than (> ) 5.5 following insertion. The x-ray request form must be marked
as urgent and the film reviewed as soon as possible. The time of tube insertion
must be documented on x-ray request forms as this will assist Radiology in
prioritising investigations to be undertaken. An urgent x-ray should be undertaken
within 4 hours of the request.

X-rays must be interpreted and nasogastric tube position confirmed by a
Healthcare professional assessed as competent to do so. If there is any difficulty
in interpretation of the x-ray, the advice of a radiologist should be sought.

Remote reviewing of an x-ray should be followed up by a review of the patient
and appropriate documentation before the tube is used for feeding.
A nasogastric tube identified to be in the lung must be removed immediately, whether in the radiology department or clinical area.

**Note** an x-ray only confirms the position at the time the image was taken.

A flowchart for the procedure for confirming correct position of a nasogastric tube can be found on page 15. A summary of the rationale for these procedures can be found on page 16.

**15. Confirming correct position during ongoing care**
Radiography **should not** be used for daily confirmation of tube position due to increased exposure to radiation, impracticality, costs and disruptions to feeding.

The following should be considered:

- Avoid testing after administration of medication, as this may cause changes in gastric acidity
- During continuous feeding it may be difficult to obtain aspirate with a pH of the correct value, as the feed will raise gastric pH
- Aspiration of partially digested food or feed in the alert patient with an intact cough and swallow reflex is indicative of gastric placement
- If unable to aspirate and the patient is able to drink, ask the patient to drink an easily identifiable fluid. If this is then aspirated from the feeding tube, correct positioning is confirmed
- If the measurement of the tube length remains unchanged and the patient’s clinical condition is unchanged then this would support the view that the tube is still correctly positioned

Clinical judgement and expertise should be combined with the above in deciding if the tube is correctly positioned, particularly when the correct pH cannot be obtained.

An individual risk assessment should be carried out for each patient. For example, if the pH is constantly higher than 5.5 on each occasion the tube is aspirated, but on x-ray the tube is found to be correctly positioned, then it could be accepted that for this patient a pH of >5.5 is ‘normal’ and feeding can continue. This should be clearly documented.

**If in any doubt following a difficult placement and patients with a reduced level of consciousness a chest x-ray may be needed.**

**16. Securing the tube**
The tube should be well secured to the patients’ nose and cheek. In children the tape should be at least three times the diameter of the tube and long enough to cover at least two thirds of the child’s cheek.

Allergies and sensitivities to the tape may require a hydrocolloid dressing to provide a protective layer between the skin and tape. Additional fixation devices including Statlock nose plasters and nasal bridles are available from the Nutrition Support Team.
17. Documentation
The following must be documented in the medical or nursing records.
- verbal consent if appropriate
- time and date of insertion
- type and size of tube
- how correct position was confirmed
- length of tube at nostril
- person undertaking the procedure

The pre-printed sticker provided by the manufacturer should be used wherever available to standardise documentation.

Documentation following pH testing must be recorded on the daily care record (page 21) and must include:
- whether aspirate was obtained
- what the aspirate was
- who checked the aspirate pH
- when it was confirmed

Documentation following x-ray must include:
- who authorised the x-ray
- who confirmed the position of the tube
- confirmation that the x-ray viewed was the most current for the patient
- rationale for the confirmation of position of the nasogastric tube i.e. how placement was interpreted and clear instructions as to required actions

A full multidisciplinary supported risk assessment must be made and documented, before a patient with a nasogastric tube is discharged from acute care to community (page 17).

18. Resources
This procedure is a revision of existing guidelines within the UHB. There are minimal resources required for implementation. All nasogastric tubes are available through CSSD. pH indicator strips are available from pharmacy and additional securing devices including Statlock nose plasters and nasal bridles are available from the adult Nutrition Support Team.

19. Training
The adult Nutrition Support Team undertakes a quarterly education and training programme “Passing a fine bore nasogastric tube”. This is open to all staff – doctors, nurses and allied health professionals and booked through the Learning, Education and Development department.

An e-module training tool for x-ray interpretation of nasogastric tube position is available at www.trainingngt.co.uk

In paediatrics relatives will be trained how to insert, confirm correct position and manage the nasogastric feeding tube by an appropriately trained paediatric nurse using a training checklist.
20. Responsibilities
Healthcare professionals must ensure that if involved with nasogastric tube placement and confirmation of position they have been assessed as competent through theoretical and practical training. Practitioners and Ward managers are responsible for recording this on the ESR system. Individual directorates are responsible for implementing the procedure. The Nutrition Support Team will continue to provide the training and support of staff undertaking the procedure. Incident forms must be completed for misplaced nasogastric feeding tubes or other adverse events associated with their use. Serious clinical incidences must be escalated to the Patient Safety and Quality Department.

21. Implementation
The procedure will be available on the UHB Clinical Portal and Intranet site. The Nutrition Support Team will also ensure that specific clinical areas are aware of its content where they deem this appropriate.

Adherence to the procedure will be audited on an ad hoc basis by the Nutrition support team. It is encouraged that directorates include this to their audit calendars as appropriate.

22. Equality Impact Assessment
Cardiff and Vale UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff, patients and others reflects their individual needs and does not discriminate, harass or victimise individuals or groups. These principles run throughout our work and are reflected in our core values, our staff employment policies, our service standards and our Strategic Equality Plan & Equality Objectives. The responsibility for implementing the scheme falls to all employees and UHB Board members, volunteers, agents or contractors delivering services or undertaking work on behalf of the UHB.

An Equality Impact Assessment was undertaken in 2009 when this Procedure was last reviewed. At that time it was determined that the Procedure presented a low risk. A further Assessment to assess any possible or actual impact that this revised procedure may have on any groups in respect of gender, maternity and pregnancy, carer status, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics will be undertaken and reported on when complete.

22. Review
This procedure will be reviewed every 3 years or sooner if appropriate.
23. References


Procedure for passing a nasogastric feeding tube and confirming correct position

**Equipment**
- Fine bore tube of appropriate size
- pH indicator paper
- Nose plaster or appropriate tape/scissors
- Non-sterile gloves
- Apron
- 60 ml purple enteral syringe
- Glass of water/straw (if appropriate)
- Tissues
- Receiver
- An assistant

**Procedure**
1. Wash hands according to UHB policy and assemble the equipment.
2. Prepare the patient for the procedure:
   - Screen bed area
   - Explain procedure and rationale
   - Where appropriate obtain verbal consent and document
   - Clean/clear nostrils and provide oral care
   - Position patient (semi-recumbent, head tilted slightly forward)
   - Agree signal to pause/stop the procedure
3. Wash hands, put on gloves and apron.
4. Examine tube and integrity – ensure the guide-wire moves freely.
5. Measure the length of the tube required (NEX) and mark with indelible pen.
   - Adults - nose to earlobe to xiphisternum (usually 50-65 cm)
   - Children – nostril to edge of cheek, ear to stomach
6. Do not use lubricating agents with fine-bore tubes as these may affect pH readings or occlude the tube.
7. If able to swallow, provide the patient with a glass of water with a straw.
8. Insert the tip of the tube into the nostril, along the floor of the nasal passage into the oropharynx (throat), ask the patient to swallow and tilt chin down slightly.
9. Advance the tube gently and encourage the patient to swallow until the tube reaches the measured length.
   If the patient shows signs of distress e.g. excessive coughing, gasping or cyanosis, the tube must be removed immediately. Referral must be made to a senior member of the medical team who will review the situation and...
determine what action is necessary. This may include referral for assistance from the Nutrition Support Team or other appropriate clinical team. Out of hours, the responsible clinical team must risk assess further attempts at insertion versus delay in provision of enteral nutrition.

10. Confirm correct position of nasogastric tube

**Procedure to confirm correct position following insertion:**
- Use a 60 ml enteral syringe and slowly aspirate fluid (only a small amount (1 ml) is needed).
- Place aspirate on pH strip and leave for 10 seconds. A reading of **5.5 or below** indicates gastric placement.
- In addition to pH measurement, x-ray on initial placement is advisable in patients in whom the procedure was difficult i.e. coughing/vomiting or if there is any doubt regarding the pH obtained.

**If aspirate is difficult to obtain try some or all of the following:**
- Check the syringe size - must be ≥ 20 ml
- Check the tube is inserted to correct length as measured (NEX).
- Try advancing or withdrawing tube 5 -10 cm (adults) and 1-2 cm (children and infants)
- Flush tube with air. Use 10-20 ml of air in adults or 1-2 ml of air in children and infants. Do NOT use water.
- Ask the patient to drink water if appropriate (i.e. safe swallow)
- Position the patient on their left side
- Wait up to 30 minutes and retry

**If all attempts to obtain gastric aspirate fail on initial placement, a chest x-ray must be requested.**

**If aspirate is greater than 5.5:**
- Ask the patient (if appropriate) to drink an easily identifiable liquid and then aspirate the tube.
- Consider other surrogate markers of tube position such as previously recorded pH measurements and external tube length.

**If attempts to obtain gastric aspirate pH of 5.5 or less fail on initial placement, a chest x-ray must be requested.**

**Following confirmation of position:**

11. Remove the guide-wire. Flush 5 ml of water through the tube using a 20 ml enteral syringe. Hold the tube firmly at the nose and carefully remove the guide-wire. **Never re-insert the guide-wire whilst the tube is in the patient.**

12. Secure the tube by taping around the tube and across the nose. Position the tube to the corner of the nostril. Additional tape may be used to secure the tube to the patient’s cheek.
13. Dispose of waste according to UHB policy.

14. Document consent, the procedure and method of confirming correct tube position including the person undertaking the procedure in the medical or nursing notes as appropriate.

**Procedure for ongoing care of a patient with a nasogastric tube**

- Check tube position prior to giving feeds/drugs as per previous instructions. Record daily NG checks on the nasogastric daily care record (page 20).

- If on continuous feeding, stop feed and flush tube with 30 ml water prior to aspiration, use clinical judgement and surrogate measures (tube length etc) to decide if tube is correctly positioned if pH > 5.5.

- If unable to aspirate/obtain correct pH use clinical judgement and surrogate measures (tube length etc) to decide if tube is correctly positioned.

- Flush the tube with water before and after feeding, before and after medication and between each medication.

- Use sterile water for all children and infants. Adults that are immuno-compromised or critically ill should also have sterile water. Freshly drawn drinking water is suitable for other adults.

- Do not place 3 way taps or other intravenous connectors between the nasogastric tube and enteral giving set.

- Only enteral syringes that are labelled “enteral” should be used to measure and administer medication. Do not use intravenous syringes.

- Check the securing device on each shift and renew regularly, and record on daily care record.

- Check the nostril with the nasogastric tube regularly. Clean with water as needed. Adjust position in nostril if necessary and document on daily care record.

- Consider changing tube after 28 days (Medicina), 7-10 days (PVC/Ryles) or sooner if needed (risk assess).
Procedure for confirming correct positioning of nasogastric feeding tubes in adults, children and infants

Aspirate 0.5–1ml using gentle suction with 60ml syringe and test on pH strip, wait 10 seconds and use colour reference guide to determine pH

- **No aspirate obtained**
  - **DO NOT FEED**

- **Aspirate obtained**
  - **PH 6 or more**
    - **Risk assess**
      - **DO NOT FEED**
  - **PH ≤ 5.5**
    - **On initial placement only:**
      - Small bowel placement – consider withdrawing tube 5-10 cm in adults, 1-2 cm in children
    - **On initial or subsequent confirmation:**
      - Some drugs may cause a temporary change in pH
      - Continuous feeding may alter pH
      - Ask patient to drink coloured liquid
      - Consider other surrogate markers of tube position e.g. tube length
      - Reposition and retry

- **NG position inconclusive**
  - **CHEST X-RAY**

- **NG position conclusive**
  - Documented in medical notes

**COMMENCE FEEDING**
### Rationale for procedure for checking the position of nasogastric tubes in adults, children and infants (not neonates)

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
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<tr>
<td>Check whether the patient is on medication that may increase the pH level of gastric contents</td>
<td>Medication that could elevate the pH level of gastric contents are: antacids, H₂ antagonists and proton pump inhibitors. The initial risk assessment should take in this scenario, and be documented in the care plan. The initial pH of the aspirate should also be documented in the care notes.</td>
</tr>
<tr>
<td>Check for signs of tube displacement</td>
<td>Documenting the external length of the tube initially and checking external markings prior to feeding will help to determine if the tube has moved. The documentation will also assist radiographers if an x-ray is needed.</td>
</tr>
<tr>
<td>Sufficient aspirate obtained (0.5 to 1 ml)</td>
<td>0.5 to 1 ml of aspirate will cover an adequate area on the panel of pH testing strips/paper. Allow 10 seconds for any colour change to occur.</td>
</tr>
<tr>
<td>Aspirate is pH 5.5 or below</td>
<td>Commence feed. There are no known reports of pulmonary aspirates at or below this figure.</td>
</tr>
<tr>
<td>Aspirate is pH 6 or above</td>
<td>DO NOT FEED. Possible bronchial secretion; leave for up to one hour and try again. The initial risk assessment should identify actions for staff to take in this scenario for each patient. The actions should be documented in the care plan.</td>
</tr>
<tr>
<td>Wait up to one hour before re-aspirating to check pH level</td>
<td>The most likely reason for failure to obtain gastric aspirate below pH 5.5 is the dilution of gastric acid by enteral feed. Waiting for up to one hour will allow time for the stomach to empty and the pH to fall. The time interval will depend on the clinical need of the patient and whether or not they are on continuous or bolus feeding.</td>
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#### Problems obtaining aspirate?

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<td>Turn patient on their side</td>
<td>This will allow the tip of the nasogastric tube to enter the gastric fluid pool.</td>
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<td>Inject air (1.5 ml for children and infants, 5-10 ml for adults), using a 20 or 60 ml syringe. Wait for 15-30 minutes and try again</td>
<td>Injecting air through the tube will dispel any residual fluid (feed, water or medicine) and may also dislodge the exit port of the nasogastric feeding tube from the gastric mucosa. Using a large syringe allows gentle pressure and suction; smaller syringes may produce too much pressure and split the tube.</td>
</tr>
<tr>
<td>Advance/withdraw the tube by 1-2 cm in children or 5-10 cm for adults</td>
<td>Advancing the tube may allow it to pass into the stomach if it is in the oesophagus. Withdrawing the tube may re-position the tube into the stomach.</td>
</tr>
<tr>
<td>Consider x-ray – all radiographs should be read by appropriately trained staff</td>
<td>X-ray should not be used routinely. The radiographer will need to know that this advice has been followed, what the problem has been and the reason for the request. The request form must be marked as urgent and the film reviewed as soon as possible. Fully radio-opaque tubes with markings to enable measurement, identification and documentation of their external length must be used. Document time of tube insertion on the x-ray request form.</td>
</tr>
<tr>
<td>Additional tip</td>
<td>If the patient is alert, has an intact swallow and is perhaps only on supplementary feeding and is eating and drinking during the day, ask them to sip a coloured drink and aspirate the tube. If you get the coloured fluid back then you know the tube is in the stomach.</td>
</tr>
</tbody>
</table>
Guidance for Community Nasogastric (NG) feeding

A multi-disciplinary team decision has been made that this patient is safe to be discharged home with a nasogastric tube for feeding/medication.

Name: ........................................................................................................................................
Designation: ................................................................................................................................
Signature of team member: Date: ........................................................................................................

Designated person(s) responsible for placement of NG tube/confirmation of NG tube position for on-going use at home: ....................................................................................................................................

If not patient please state relationship to patient: ..........................................................................................................................

Trained by........................................ Designation.................................................................

If paediatric community nursing team or district nursing support is required, their training requirements have been met:

Name of team leader for Paediatric Community Nursing/District Nurse Team .................................................................................................................................................................

Date of training: .........................................................................................................................................................

In addition to the HETF package, the patient should be provided with a supply of
- pH indicator strips
- nose plasters/fixation devices
- a copy of the NPSA advice sheet
- who to contact if the tube falls out

If the tube falls out/displaced contact details for support from acute sector:

Ward area: Contact Tel no: ..........................................................................................................................
Nasogastric Tube Competency Record

Name ..................................................

Ward .................................

I confirm that the above named member of staff has been trained and deemed competent in the insertion of a fine bore feeding tube.

I confirm that they are compliant with the UHB procedure for confirmation of correct position and on-going maintenance of the tube.

Staff Member .............................. Ward Sister/Charge Nurse

Assessor

Signature.............................. Signature..............................

Designation.............................. Designation..............................

Date.............................. Date..............................

NB: A record of the staff member’s competence must be logged on the UHB ESR system.
<table>
<thead>
<tr>
<th>Competence</th>
<th>Brief description of evidence/assessment</th>
<th>Date</th>
<th>Nurse &amp; Assessor Signature</th>
<th>Nurse &amp; Assessor Signature</th>
<th>Nurse &amp; Assessor Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Demonstrates an understanding of the Scope of Professional Practice and implications for practice.</td>
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<td>2</td>
<td>Attends a recognised formal course on NG tube placement.</td>
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<td>3</td>
<td>Refers to the Cardiff &amp; Vale NHS UHB procedure for NG tube placement and confirming correct position.</td>
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<td>4</td>
<td>Demonstrates knowledge of Relevant anatomy.</td>
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<td>5</td>
<td>Discusses and demonstrates understanding of the indications and contra-indications of nasogastric tube placement.</td>
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<tr>
<td>6</td>
<td>Discusses issues surrounding consent for the placement of nasogastric tubes.</td>
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<td>7</td>
<td>Demonstrates understanding of the range of nasogastric tubes and is able to make an appropriate choice.</td>
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<td>8</td>
<td>Demonstrates the correct procedure for tube placement.</td>
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<tr>
<td></td>
<td>Competencies</td>
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<td></td>
<td>Undertakes the procedure with due regard to all aspects of health &amp; safety and maintains patient comfort throughout.</td>
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<td>9</td>
<td>Demonstrates the correct procedure for confirming correct position of nasogastric tubes.</td>
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<td>10</td>
<td>Discusses action to be taken if aspirate cannot be obtained or is above the required pH.</td>
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<td>11</td>
<td>Discusses the use of surrogate measures for determining tube position.</td>
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<tr>
<td>12</td>
<td>Discusses methods that should not be used to confirm correct tube position.</td>
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<td>13</td>
<td>Demonstrates securing of the tube in the most appropriate way for the patient.</td>
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<td>14</td>
<td>Demonstrates correct documentation of procedures.</td>
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<td>15</td>
<td>Demonstrates an understanding of the incident reporting process.</td>
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Note: If more than 3 supervised practices are required use additional sheets.
Daily care record for Nasogastric feeding tube

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>pH</th>
<th>Length at nose (cm)</th>
<th>Secured well</th>
<th>Comments</th>
<th>Signature or initial</th>
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Note: Refer to the UHB procedure “Insertion of a nasogastric tube, confirmation of correct position and ongoing care, in adults, children and infants”. Contact the Nutrition Support Team for further information.