Title: **POLICY FOR THE USE OF NASOGASTRIC TUBES (NGT) AND THE SAFE ADMINISTRATION OF FEED AND MEDICINES VIA ENTERAL ROUTES**

Ref No: 1862 Version 6

Classification: Policy

Directorate: Professional Practice, Education

Due for Review: 28/04/20

Responsible for review: Nutrition Specialist Nurse Team

Document Control

Ratified by: Care and Clinical Policies Group

Applicability: All patients as indicated

Contents

1 Purpose

1.1 This policy will improve safety and patient comfort when using nasogastric tubes (NGT) by ensuring that clinical practice conforms to National and Local standards. The scope of this policy covers insertion of nasogastric feeding tubes, management of established enteral feeding systems and feeding via enteral systems.

1.2 This policy does not cover preparation for or insertion of other types of enteral feeding tube including Jejunal or Percutaneous Endoscopic ally inserted Gastrostomy tubes (PEJ and PEG).

1.3 PEG Tubes are covered by the TSDFT Percutaneous Endoscopic Gastrostomy (PEG) Tube Feeding and Medication Administration for Adults in the Community Setting Policy. Version 1 (2015) and TSDFT Medicines Policy 0806, Version 7 (2015)

2 Introduction

2.1 Artificial feeding via enteral tubes might be considered for patients who are malnourished or at risk of malnutrition: especially, but not exclusively, those with swallowing problems. The insertion of nasogastric tubes can be an uncomfortable procedure for patients and should only be performed by, or under supervision of, a practitioner who is competent in the task.

2.2 Nasogastric feeding is a relatively common practice but it carries a risk of death or medical complications if the tube is misplaced or there is displacement into the lungs. This clinical procedure has been subject to National Patient Safety Alerts (NPSA), and mental capacity and

consent must be considered in line with the Trust Consent Policy and the Mental Capacity Act (2005)

3 Roles and Responsibilities

3.1 The Director of Professional Practice, and the Patient Safety and Quality Manager are responsible for ensuring the policy is embedded in practice: Incidents must be reported as a clinical/patient safety incident using the Trust's incident reporting procedure. Incidents must be investigated appropriately, and action plans acted upon with learning disseminated across the Trust.

3.2 Nutrition Specialist Nurses, Ward Managers and Matrons in both the District General Hospital (DGH) and Community Hospitals, community nursing leads and other clinical leads are responsible managerially for ensuring all staff are aware of and working to this nasogastric tube policy. They must ensure staff are trained and signed off as competent to insert and manage nasogastric tubes in the clinical setting.

3.3 Clinical Staff are responsible for attending training in nasogastric tube insertion, completing the competencies and complying with this policy, the Trust Consent Policy and Mental Capacity Act (2005).

3.4 Staff must acknowledge any lack of competence in regard to assessment of patients, insertion and management of nasogastric tubes. They must be competent in ensuring the tube is properly positioned before administering enteral feed or medications.

3.5 Clinicians are responsible for documenting the clinical justification for nasogastric feeding, risk assessment, insertion of, and management of a nasogastric tube for each patient, ensuring the patient and their relatives understand the rationale for nasogastric feeding. This must be reviewed according to changes in the patient's condition.

3.6 Carers of patients receiving food or medicines via nasogastric must be educated about the risks and complications in using the equipment, how to use it safely, and to immediately report incidents, including patients developing chest infections, using the Trust incident reporting procedures. Documentation of all interventions should be completed at the point of care with the patient.

3.7 Gastroenterology Leads must liaise with suppliers to ensure all products relating to nasogastric insertion and care aligns with national guidance.

4 Main body of the document

4.1 **The aims and objectives** of this policy are to safely initiate the insertion and management of nasogastric tubes in the Community and Community Hospitals. Where other feeding systems are indicated, the patient must be referred to the relevant acute provider for consultant assessment and consideration. Clinicians should then follow the acute provider guidelines for procedure preparation and aftercare as these may vary between different Trusts

5. Scope of the document:

5.1 Enteral feeding can be fraught with ethical and legal dilemmas and clinicians should refer to the Consent Policy, Mental Capacity Act and also familiarise themselves with guidance from the British Medical Association (BMA) and British Association of Parenteral and Enteral Nutrition (BAPEN) who publish up to date guideline on line. There is an ethical duty to provide nutrition and hydration to patients who need it but enteral feeding is classed in law as a medical intervention and the rules of consent to treatment apply. Where patients are unable to consent to enteral feeding, there must be a Best Interests decision with rationale for the treatment clearly documented in the medical notes by the lead clinician responsible for the individuals care.

The decision to start artificial feeding should normally be taken following discussion within a multidisciplinary team and with the patient (or significant others if the patient lacks capacity) or parent/carer. In all cases the decision to start artificial feeding must be taken by at least two competent clinicians, one of which must be the senior doctor who has responsibility for care.

The decision must be clearly documented in the patient record before the tube is inserted, with an individual risk assessment balancing the need against the risks of enteral feeding. In all cases, the decision process must comply with the Consent Policy.

5.2 Assessment for Ng Tube (NGT), Inclusion and Exclusion Criteria:

NG feeding is rarely clinically urgent in a community hospital or community setting and so insertion can usually be deferred until conditions are right. However, if there is an urgent need for a feeding tube and it cannot be safely inserted in the current setting then referral to an acute hospital may need to be considered.

Key questions to ask before deciding to insert a nasogastric tube are (NSPA 2011):

- Is nasogastric feeding the right decision for this patient?
- Is this the right time to place the NG tube and is the appropriate equipment available?
- Is there sufficient knowledge/expertise available at this time to test for safe placement of the nasogastric tube?
- Are there x-ray facilities available if the pH test is inconclusive?

5.3 Contra-indications for NGT insertion:

- Maxillo – facial disorders, surgery or trauma
- Oesophageal tumours or surgery
- Laryngectomy
- Patients who have had oro-pharyngeal tumours or oro-pharyngeal surgery.
- Skull fractures
- Nasal Continuous Positive Airway Pressure
- Unstable Cervical Spinal Injuries (V4 or above).
- Oesophageal varices

5.4 Cautions:

- Confirming an aspirate pH value of between 1 and 5.5 can reliably exclude pulmonary placement of an NG tube (NPSA 2011) but there is still a small risk of oesophageal placement which carries a higher risk of aspiration. Patients receiving anything via a NG tube should therefore still be monitored for signs of aspiration.

- There is an increased risk of tube misplacement or migration in patients who have a reduced level of consciousness, confusion, cognitive impairment with agitation, impaired swallow or experience bouts of retching, coughing or vomiting.

- There is also an increased risk of aspiration due to gastric reflux in patients with reduced level of consciousness, impaired swallow, a history of gastro-oesophageal reflux or who have mobility problems and remain supine during feeding.

- Patients taking antacids, H2 antagonists or proton pump inhibitors are more likely to have a stomach pH greater than 6 in which case it may be difficult to confirm tube placement with the necessary accuracy. The need to continue this medicine should be reviewed by the prescriber and discussed with the Gastroenterology Team against the need to feed via NGT: Advice given for any variations in practice should be documented.

- Nasogastric tube insertion can be dangerous as well as difficult in patients with altered anatomy, for example oesophageal fistula or pharyngeal pouch or in certain clinical conditions, such as basal skull fracture. In these situations, or if these are suspected, senior clinical help should be sought and nasogastric tube insertion should only be attempted in the Acute Trust and transfer of the patient would be necessary.

- If patients are at risk of re-feeding syndrome, as per Re-feeding Syndrome Policy https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/Clinical%20Effectiveness/G1119.pdf please initiate feeding as per re-feeding policy guidelines..

6 Training and Supervision

6.1 Training will be provided by the Nutrition Specialist Nurses or other trainers who have the experience of Ng Tubes and are recognised by the trust. The trust Clinical Skills Facilitators must ensure they have attended nasogastric tube insertion and management training with the Nutrition Specialist Nurses, have been assessed and are confident and competent to teach this skill.

6.2 All staff who are required to insert and maintain nasogastric tubes must undertake training including theoretical knowledge and practical training and assessment. (see competence assessment APPENDIX 4)

6.3 Delegation of undertaking Ng medication administration to carers, following training and assessment is the responsibility of the Registered Nurse signing them off as competent.

6.4 Currently, community nursing teams do not undertake Ng Tube insertion on a regular basis, and will need training to maintain this skill if numbers increase. As with the patients with PEG Tubes, a patient folder will be left in the home with emergency contact numbers, records of assessment and competence of each carer

7 Equipment required for Inserting a Nasogastric tube

- Ng tube size 6ch to 8ch for adults
- Non-Sterile gloves
- 50 ml ENFIT compliant enteral syringe
- Water to lubricate the tip of the tube before insertion
- Jug
- pH testing strips with 0.5 indicator gradations that is CE marked and manufactured to test human gastric aspirate.
- GRIPLOK ™ nasal gastric securement device.
- Drinking water
- Clinically clean tray

8. Guidelines for inserting and securing nasogastric tubes

8.1 The patient should preferably be in an upright sitting position, supported if necessary.

8.2 Give a careful explanation of the procedure, inform the patient that they will experience some discomfort during the procedure and agree with the patient some means by which they can command you to stop for a moment during insertion.

8.3 Ensure nostrils are clear, and clean as necessary with tissue if not. Check which is the largest nostril as this should be the preferred nostril for the procedure. In stroke patients the side with parathesia is often chosen due to decreased sensation.

8.4 Wash hands and apply non sterile latex free gloves

8.5 Measure the tube (NEX Measurement) from the bridge of the nose to the ear plus the distance from the bridge of the nose to the xiphisternum.

8.6 Lubricate the tip of the tube with water; do not use lubricating gel as this may alter the pH value of the aspirate.

8.7 Insert the tube, sliding it backwards and inwards along the floor of the nose. During insertion, observe for signs of excessive coughing, respiratory distress and choking. If these occur withdraw the tube and try again. Remember, these signs may be absent in any patient but especially those who have neurological impairment or a reduced level of consciousness.

8.8 If the patient is able to swallow then the procedure is made easier by asking the patient to slowly drink water once the tip of the Nasogastric tube reaches the back of the throat.

8.9 The tube can be positioned either on the front of the nose and then fixed on the forehead or to the side and fixed to the cheek. The choice may depend on the level of consciousness of the patient, their cognition or whether they are prone to perspiring. Secure with a GRIPLOK ™ nasal gastric securement device. Tape is no longer used due to infection control reasons.

8.10 Note and record the number on the NGT.

8.11 Confirm the nasogastric tubes position before removing the guide wire from nasogastric tube as it is easier to manipulate the tube if the guide wire is still insitu.

9 Checking NG tube placement

The responsibility for ensuring correct tube placement lies with the nurse caring for that patient and he/she must be satisfied that the tube is correctly placed before commencing or continuing with feeding or drug administration via the NG tube. Follow the appropriate protocol for checking nasogastric tubes placement (Appendices 1, 2 and 3)

9.1 Tube insertion must be documented in the patient notes including:

- Consent for procedure or mental capacity assessment and best interest decision
- Date and time of insertion
- Tube type
- Method and result of placement confirmation
- Method for securing the tube
- External tube length remaining

10 The position of the tube must be checked at the following times:

- On insertion
- Before administering each feed
- Before giving medication if at a different time to feed administration
- Following episodes of vomiting, retching, coughing or other potential causes of tube displacement
- If there is evidence of possible tube displacement (e.g. external tubing appears longer)
- At least every 24 hours
- **More frequent checking might be indicated for certain patients**
- (e.g. Agitated,cognitively impaired or confused patients).
- A note must be made on the patient record every time that the tube placement is checked using the form in APPENDIX 2 stating:
- What time the check was made
- The value of the pH result (i.e. it is not acceptable to record ‘within range’ or similar)
- Who performed the check including name and role

- **Misplaced feeding tube incidents must be reported through the Trust incident reporting system Datix.**

11. Tube placement should only be confirmed by testing the pH of aspirate or by x-ray. The following methods are NOT reliable for confirming tube placement and MUST NOT BE USED:

- Auscultation of air insufflate through the tube ('whoosh' test)
- Testing pH using blue litmus paper
- Monitoring bubbling at the end of the tube immersed in liquid
- Observation of feeding tube aspirate
- Interpreting absence of respiratory distress as an indicator of correct positioning

12. Aspirated Fluid Testing:

Aspirated fluid is tested using pH sticks that must be CE marked and manufactured specifically for the purpose of checking the pH of human gastric aspirate. Litmus paper must not be used, as it does not give an accurate measure of pH value (Medicines and Healthcare products Regulatory Agency MDA/2004/026)

12.1 **Interpretation of the pH result:**

- A pH value of less than 5.5 excludes tube pulmonary placement and it is therefore safe to commence administration of feed/medicines via the tube.
- A pH value greater than 5.5 indicates possible placement in the intestine or tracheobronchial tree. (Follow pathway at Appendix 3)

12.2 If there is any doubt about the pH value (especially in the 5-6 range) then feeding solution and medicines should not be administered via the tube. Refer immediately to the independent prescriber for the patient concerned if medicines cannot be administered.

12.3 Testing of tube placement should normally be performed no less than one hour before administration of feed or medicines

12.4 When patients are receiving continuous feed it may be impossible to obtain an aspirate within the pH range. In this circumstance, so long as tube placement has been confirmed at the start of feeding and that there are no other reasons to suspect tube displacement, it is acceptable to check that the external length of tube has not changed before cautiously administering medicines via the NG tube.

12.5 If tube placement cannot be confirmed by pH testing then confirmation by x-ray is essential.

12.6 The request form must clearly state that the purpose of the x-ray is to establish the position of the NG tube for the purpose of feeding.

12.7 It is the radiographer's responsibility to ensure that the NG tube can be clearly seen on the x-ray to be used to confirm tube position.

12.8 X-rays must only be interpreted and NG tube position confirmed by someone assessed as competent to do so.

12.9 If there is any difficulty in interpretation the advice of a radiologist should be sought.

12.10 **Where x ray facilities are not available for 48 hours it is essential to transfer the patient to the local acute trust for X-ray.**

- **Where x-ray facilities will be available under 48 hours wait, the NG tube must be clearly marked not for use and all staff informed. Consider other modes of administering medication and hydration/ nutrition**

- **Any NG tubes identified to be in the lung should immediately be removed, whether in the x-ray department or clinical area, and reported via Datix**

13. Documentation following X-ray should include:

- Who authorised the x-ray?

- Who confirmed the position of the nasogastric tube? This person must be evidenced as competent to do so.

- Confirmation that any x-ray viewed was the most current x -ray for the correct patient

- The rationale for the confirmation of position of the nasogastric tube i.e. how placement was interpreted, and clear instructions as to required actions

Example: 20th September 2011, 10:30 Dr A Smith GMC number
x- ray taken at 10.15 am on 20.9.11
NG tube passed down midline, past level of diaphragm and deviates to left
Tip is seen in stomach
Plan: NG tube is safe to use for feeding
Dr.A.Smith
Dr A. Smith

14. NG tube maintenance

14.1 Check tube position at least every 24 hours and at each intervention for feeding or medication administration

14.2 Flush with a minimum of 50mls for adults of cooled boiled water prior to and after feed or medication

14.3 Check skin around insertion site and around Griplok ™

14.4 Change tube based on the patient's condition/ tube functionality and manufacturers guidance

14.5 If tube blocks, try instilling 10-20mls for adults of warm water or soda water

15. Bolus feeding via NG tube

15.1 Where the patient's condition is likely to cause frequent self- extubation, continuous feeding should be avoided because of the increased risk of aspiration. Such patients may include those who are agitated, cognitively impaired or confused. Alternatives will depend on the reason for the need for artificial feeding but might include bolus feeding via NG tube or referral for percutaneous endoscopic gastrostomy tube.

15.2 A bolus feeding regime must be established in consultation with a dietician who will calculate the volumes and type of feed according to the frequency with which it can be administered.

15.3 Tube position must be confirmed before each administration of bolus feed.

15.4 To minimise the risk of aspiration during bolus feeding the patient should be in a sitting position (or with the head of bed elevated to approximately 45 degrees). The patient must be closely observed for signs of aspiration following administration of the feed bolus.

15.5 Incidents involving misplaced or displaced tubes must be reported via Trust incident report procedures to enable local and national monitoring of risks associated with nasogastric feeding.

16 Administering medicines via enteral feeding tubes

16.1 Medicines should be prescribed specifically for administration via enteral feeding tubes as this route involves an off-licence prescription for most medicines.

16.2 Staff must follow Standard Operating Procedure for Medicines administration via Enteral Feeding Tube (May 2015) version1.1 and TSDFT Medicines Policy version 7

16.3 The prescription must state the form or instructions for the preparation of solution required e.g. dissolve tablet in water, suspension or syrup solution etc.

16.4 The prescription must take into account changes in bioavailability of the drug in different forms. If in doubt consult a pharmacy advisor.

16.5 **Altering the state of medicines prior to administration generally means administering the medicine off-licence.** Therefore if problems are encountered, inform the prescriber as soon as possible and consider contacting a pharmacy advisor.

16.6 Medicines must not be mixed. All medicines should be administered separately and the tube flushed with 5-10mls of water in between. Some drugs may require bigger flushes in-between due to viscosity, or difficulty in dissolving

16.7 Medicines for enteral administration should only be measured or administered using purple syringes labelled for oral/enteral that cannot be connected to intravenous or other ports. 60ml purple enteral Catheter tip syringes are not sufficiently accurate to measure small quantities of medicine, therefore choose an oral/enteral syringe of suitable size, draw up the medicine, put into a medicine pot, and add 10mls of water to make up to sufficient amount for administration using the purple 60ml syringe

16.8 Do not use male luer-lock or male luer-slip syringes used for intravenous drug administration to measure or administer medicines to be given via an enteral route

16.9 The ports and reservoirs of enteral feeding systems should be labelled as being for enteral administration only.

16.10 Ports (i.e. three way taps) and syringe tip adaptors should not be used with enteral systems in any circumstances as this might lead to safety design features being bypassed.

16.11 Preparation and administration of medicines via enteral routes should be completed as a single process for each medicine. Where multiple medicines need to be administered

enterally to a patient, each medicine should be given separately with a flush between each drug. In hospital, acute or community, each medicine should be prepared and administered before drawing up the next medication. Any unlabelled syringes should not leave the hands of the person administering the medicine.

16.12 Enteral feeding tubes should be flushed with at least 30 mls of water when medicines administration is complete in order to avoid tube blockage. Syringes are single use in the acute and community hospitals.

17 Carers In the community administering enteral tube drugs:

To enable patients to remain at home or in community residential and nursing homes, carers and support workers are taught how to care for patients with enteral tubes, give enteral feed, water boluses and undertake the drug administration process through 3rd party delegation by Registered Nurses: This involves the community nurses assessing the carers twice following client Specific medication training, to ensure they are competent to undertake the task, before delegating the medication administration to them. The patient and carers are supported by the community nurses, and carers are re-assessed every 6 months for medication administration, or earlier if necessary.

17.1 At present, carers are not taught to administer anything via Ng tubes as there are so few patients with them at home, or in nursing homes. The Community Nurses cannot delegate this task as they do not undertake it.

17.2 **The preparation and administering process for enteral tube drugs is the same as in the hospitals except:**

- Purple 60ml enteral syringes used in the patient's homes, generally need to be changed weekly. Some patients may have single use syringes and this should be documented to ensure they are replaced accordingly.
- Cooled boiled water is used instead of sterile water to dissolve medications and provide flushes.
- If the patient is on a fluid balance chart, carers are advised to start the drugs administration with one litre of water, and calculate how much water has been used after the medication administration which includes all flushes before, in-between and after each drug.

18 Infection Control

18.1 Preparation and storage of feed: Feeds should be stored according to manufacturers' instruction and standard food hygiene regulations

18.2 Administration of feeds: The use by date of the feed should be checked before administering.

18.3 Minimal handling and an aseptic non-touch technique should be used to connect the feed container administration system and enteral feeding tube.

18.4 Unused sterile feed should be discarded after 24 hours. Unused non-sterile feed should be discarded within 4 hours

19 Care of the insertion site and enteral feeding tube:

19.1 The nasal mucosa is at particularly high risk of trauma during naso-gastric feeding and should be checked each time the tube placement is rechecked.

19.2 Enteral feeding tubes for patients who are immunosuppressed should be flushed with either cooled freshly boiled water or sterile water from a freshly opened container.

19.3 Water for flushing: In a community or community hospital setting, cooled boiled water can be used for flushing enteral feeding tubes except for Jejunal tubes or Peg tubes with jejunal extensions which must only be flushed with sterile water. This is because the jejunal system bypassed the stomach acid which would normally cope with the pathogens (DOH 2009)

20 Monitoring and Auditing

20.1 The Patient Safety and Quality Lead in conjunction with the Head of Nursing will put in place a programme to monitor compliance and effectiveness of this policy.

22. Process for Monitoring Compliance and Effectiveness

22.1 The programme for monitoring will include reviewing incidents reported through the incident reporting process; be part of the process relating to maintenance of medical devices identified in the medical devices policy and regular audits including:

22.2 Prospective audit of the incidence of chest infection in patients receiving nasogastric feeding

22.3 Review of the measurement and administration of enteral liquid medicines as part of the annual medicines management audit

23. References

23.1 DOH (2010) Essential Steps to Safe, Clean Care – Enteral Feeding

23.2 National Patient Safety Agency 2007 Patient Safety Alert 19: Promoting safer measurement and administration of liquid medicines via oral and other enteral routes. 28/03/07

23.3 National Patient Safety Agency (2011) Patient Safety Alert: Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants NPSA/2011/PSA002

23.4 National Patient Safety Agency 2010 Rapid Response Report: Early Detection of Complications after Gastrostomy NPSA/2010/RRR010

23.5 National Patient Safety Agency: Never Events Framework 2009-2010: Guidance

23.6 TSDFT Medicines Policy 0806, Version 7 (2015)

23.7 Delegation of level 3 tasks to Skilled Not Registered (SNR) workers not employed by Torbay and South Devon Foundation Trust (TSDFT) Policy 1869. Version 5. August 2015

23.8 TSDFT Consent for Examination and Treatment Policy. Ref: 0356 Version 27

23.9 Mental Capacity Act 2005 Policy – Practice Guidance Torbay Care Trust March 2011

24. Distribution:

24.1 Community hospital matrons
24.2 Community nursing leads

24.3 Community nurses
24.4 Ward based nurses
24.7 Education leads
24.8 Clinical Skills Facilitators
24.9 Radiographers working within Torbay and southern Devon Care Trust
24.10 Medicines Management Team
24.11 Nutrition Specialist Nurses
24.12 Dietetic department

25. Equality and Diversity

25.1 This document complies with the Torbay and South Devon Equality and Diversity statements.

27. Further Information

26.1. This skill will need to be taught to Community Hospital Staff and Community Nurse Teams by the Nutrition Specialist Nurses if nasogastric tubes are used frequently in the community. At present, with such low numbers, nasogastric tube insertion and management need to be patient specific skills.

28. Links to policies:

- TSDFT Medicines Policy 0806, Version 7 (2015)
- Delegation of level 3 tasks to Skilled Not Registered (SNR) workers not employed by Torbay and South Devon Foundation Trust (TSDFT) Policy. Version 5. August 2015
- TSDFT Consent for Examination and Treatment Policy. Ref: 0356 Version 27

29. Best Practice Information: National and local policies and guidelines referenced

30. Forms/Recording Documentation: See appendices

Appendix 1 - Nasogastric tube placement bedside checklist
Appendix 2 - Nasogastric tube position confirmation record
Appendix 3 - Confirming the correct position of nasogastric feeding tubes in ADULTS
Appendix 4 - Competencies for Enteral Feeding
Appendix 5 - Linked to Alert Notice "Insertion of Nasogastric Tubes" (Dated 13 December 2016)

Appendix 1

Nasogastric tube placement bedside checklist

This bedside checklist should be completed for all patients requiring nasogastric tube placement, on insertion and on all subsequent insertions, before administration of artificial nutrition or medication via the nasogastric tube.

Patient Name:
NHS Number:
DOB:
Ward:

Nasogastric tube insertion/reinsertion

Date and time of insertion/reinsertion				
NEX Measurement				
External Length once secured				
Nostril used on insertion/reinsertion – L/R				
Aspirate obtained – Y/N				
PH of aspirate (if obtained)				
X-ray required – Y/N				
Inserted by: **Print & Sign**				
X-Ray Interpretation (if applicable)				
Date and time of x-ray interpretation				
Is this the most current x-ray – Y/N				
Is the x-ray for the correct patient? Y/N				
x-ray results e.g. "NG has passed down midline past the level of the diaphragm and deviates to the left. It is safe to feed by the NGT.				
X-ray interpreted by: **Print & Sign**				

Appendix 2

Nasogastric tube position confirmation record

Patient Name:
NHS Number:
DOB:
Ward:

The position of the nasogastric tube should be checked:

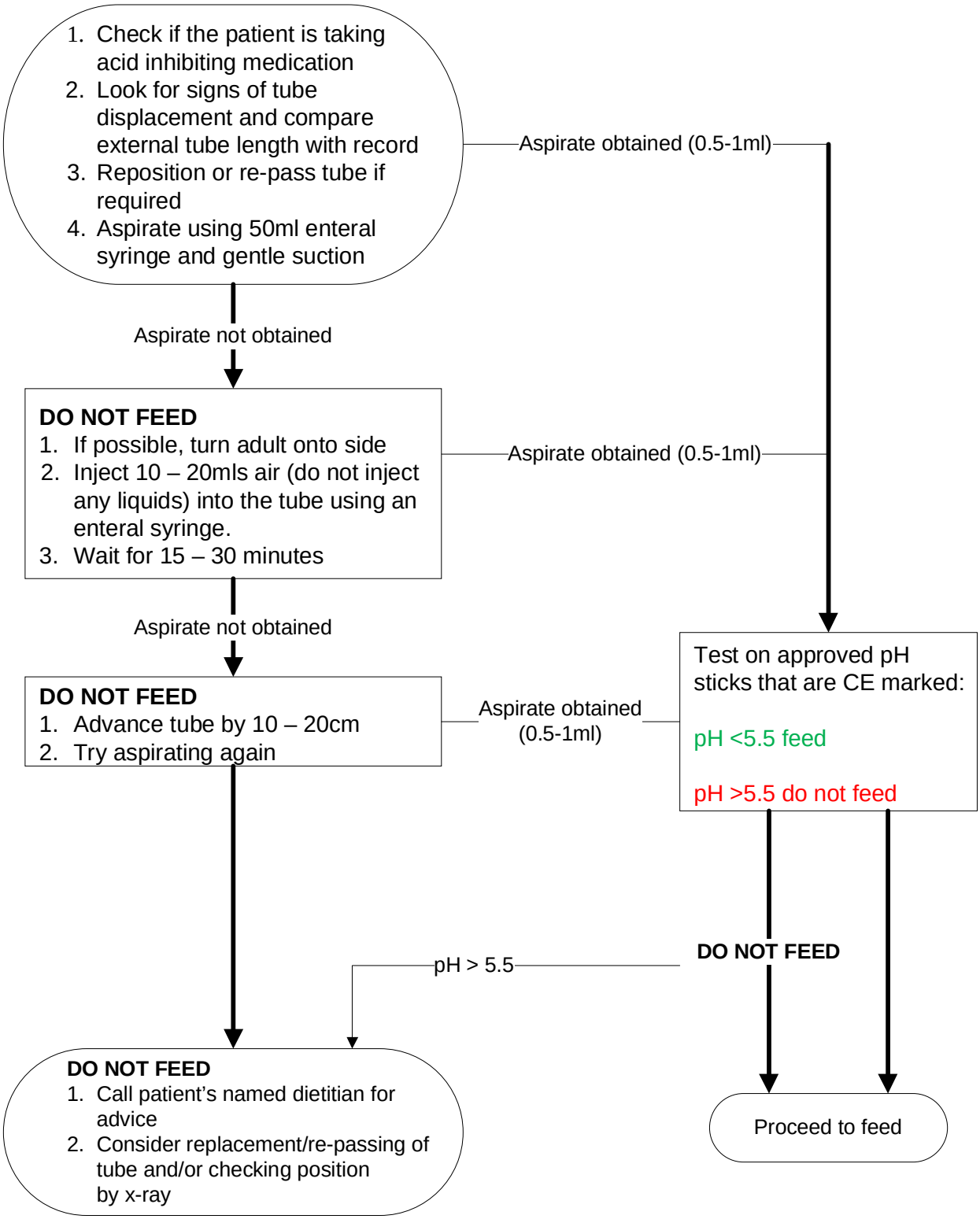
- Following initial insertion (please use placement checklist to record this).
- Before administering each feed.
- Before giving medications.
- Any new or unexplained respiratory symptoms or if oxygen saturations decrease.
- At least once daily during continuous feeds.
- Following episodes of vomiting, retching or coughing spasms.
- When there is suggestion of tube displacement.
- If you are not able to confirm that the tube is in the stomach it should be should be removed and reinserted.
- This should be documented on the nasogastric tube placement bedside checklist.

Date								
Time								
pH								
External tube length								
Checked by:								
Date								
Time								
pH								
External tube length								

If any new or unexplained respiratory symptoms, stop feed immediately and contact the medical team.

Appendix 3

Confirming the correct position of nasogastric feeding tubes in ADULTS



Caution: If there is ANY query about position and/or the clarity of the colour change on the pH strip, particularly between ranges 5 and 6, then feeding should not commence

Appendix 4

Competencies for Enteral Feeding: Inserting and securing a nasogastric tube: In order to be deemed competent to carry out the procedure of insertion and securing a nasogastric tube, the practitioner must fulfil the following criteria to a competent level

Competencies	O	A	S	C	S
Theoretical knowledge: The practitioner should have a working knowledge of:					
1.Relevant national and local policies and guidelines specific to this procedure plus policies relating to: · Infection Control · Obtaining consent · Mental capacity · Risk management and incident reporting					
2.The anatomy of the upper gastro-intestinal tract in relation to naso-gastric tube insertion including contra-indications					
3.The medico-legal implications of initiating enteral feeding					
4.Effects of pathology, age related factors or conditions that affect nasogastric tube insertion					
5. Potential benefits, risks and complications associated with nasogastric feeding					
6. The normal and potentially abnormal appearance and pH of stomach, intestinal and bronchial fluids or secretions depending on the patients' medical condition or treatment.					
7. Ability to gain informed consent					
8. Ability to reassure and support the patient during the procedure					
9. Ability to prepare and position the patient appropriately for the procedure					
10. Ability to insert a nasogastric tube in line with local policy					
11. Ability to obtain aspirate in line with local policy					
12. Ability to confirm tube placement in line with local policy					
13 Ability to secure the nasogastric tube in line with local policy					

O Observation: Awareness through observation of the performance criteria. At this stage the learner does not actively participate.
A Assistance: At this stage the learner is learning the activity but still needs the help of a registered practitioner to complete it effectively to the required level.
S Supervision: At this stage the learner can largely fulfil the performance criteria, but only with the oversight of a registered practitioner to check for safety and efficiency.
C Competent: Performing independently. The learner is competent in relation to the performance criteria
S Sustained: The competency continues to be in active use enough for the registered nurse to feel they continue to be competent in this area. Reviewed annually in development review with evidence of sustained practice

Assessor:		Assessee:	
Name:		Name:	
Designation:		Designation:	
Signature:		Signature:	
Date:		Date:	

Appendix 5

Linked to Alert Notice "Insertion of Nasogastric Tubes" (13 December 2016)

11. Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

Ref No:	1862		
Document title:	**Policy for the use of nasogastric tubes and the safe administration of feed and medicines via enteral routes**		
Purpose of document:	This policy will improve safety and patient comfort when using nasogastric tubes (NGT) by ensuring that clinical practice conforms to National and Local standards.		
Date of issue:	28 April 2017	**Next review date:**	28 April 2020
Version:	6	**Last review date:**	18 April 2017
Author:	Nutrition Specialist Nurse		
Directorate:	Operations, Professional Practice, Education		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Care and Clinical Policies		
Date approved:	16 March 2016		
Links or overlaps with other policies:	All TSDFT Trust Strategies, policies and procedure documents 0356 – Consent for Examination and Treatment 1119 – Refeeding Syndrome 1869 - Delegation of level 3 tasks to Skilled Not Registered (SNR) workers not employed by Torbay and South Devon Foundation Trust (TSDFT)		

	Please select	
	Yes	*No*
Have you considered using Equality Impact Assessment?	☐	☒
Does this document have implications regarding the Care Act? *If yes please state:*	☐	☒
Does this document have training implications? *If yes please state:*	☒	☐
Does this document have financial implications? *If yes please state:*	☐	☒
Is this document a direct replacement for another? *If yes please state which documents are being replaced:*	☒	☐

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
June 2013	3	Organisational change	CCP
February 2016	4	Update and ICO	
16 March 2016	5	Changes following consultation	Care and Clinical Policies Group

29 April 2016	5	Published on ICON	
28 April 2017	6	Amendment to Section 7 page 4 and Appendix 5 added (Linked to Alert Notice)	Nutrition Nurse Specialist
19 February 2019	6	Review date extended from 2 years to 3 years	

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

13.

Quality Impact Assessment (QIA)

	Please select			
Who may be affected by this document?	Patient / Service Users	☒	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☒	Other Statutory Agencies	☐
	Others *(please state):*			

Does this document require a service redesign, or substantial amendments to an existing process?	☐
If you answer yes to this question, please complete a full Quality Impact Assessment.	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity?	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐		
If you answer yes to any of these strands, please complete a full Quality Impact Assessment.				
If applicable, what action has been taken to mitigate any concerns?				

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☐	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☐	Other Statutory Agencies	☐
	Details *(please state):*			

NHS South Devon and Torbay Clinical Commissioning Group

Torbay and South Devon NHS
NHS Foundation Trust

Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

Policy Title (and number)	**Policy for the use of nasogastric tubes and the safe administration of feed and medicines via enteral routes**				
Policy Author	Nutrition Nurse Specialist				
Version and Date (of EIA)	Version 5: March 2016				
Associated documents (if applicable)	TSDFT Percutaneous Endoscopic Gastrostomy (PEG) Tube Feeding and Medication Administration for Adults in the Community Setting Policy V1. 2015 TSDFT Medicines Policy 0806, V7. 2015				
RELEVANCE: Does the aim/purpose of the policy relate to each of the aims of the Public Sector Equality Duty?					
· **Eliminate unlawful discrimination or other conduct prohibited by the Equality Act 2010**					Yes ☒ No☐
· **Advance equality of opportunity between people from different groups**					Yes ☒ No☐
· **Foster good relations between people from different groups**					Yes ☒ No☐
SIGNIFICANCE AND IMPACT: Consider the nature and extent of the impact, not the number of people affected.					
Does the policy affect service users, employees or the wider community? (if no, proceed to sign off)					Yes ☒ No☐
Does the policy affect service delivery or business processes?					Yes ☐ No☒
Does the policy relate to an area with known inequalities (deprivation/unemployed/homeless)?					Yes ☐ No☒
EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population? ***PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below***					
Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)					
Age	Yes ☐ No☒	Disability	Yes ☐ No☒	Sexual Orientation	Yes ☐ No☒
Race	Yes ☐ No☒	Gender	Yes ☐ No☒	Religion/Belief (non)	Yes ☐ No☒
Gender Reassignment	Yes ☐ No☒	Pregnancy/ Maternity	Yes ☐ No☒	Marriage/ Civil Partnership	Yes ☐ No☒
Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers; travellers; homeless; convictions; social isolation; refugees)					Yes ☐ No☒
Please provide details for each protected group where you have indicated 'Yes'.					
What if any, is the potential for interference with individual human rights? **(consider the FREDA principles of Fairness/ Respect/ Equality/ Dignity/ Autonomy)**					
None					
RESEARCH AND CONSULTATION					
What is the reason for writing this policy? (What evidence/ legislation is there?)					
To improve safety and patient comfort when inserting and using nasogastric feeding tubes. NPSA Guidance, Mental Capacity Act 2005, British Association of Parenteral and Enteral Nutrition (BAPEN)					
Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?					
Nutrition Specialist Nurses, Dietetics Department, Head of Professional Practice					
ACTION PLAN: Please list all actions identified to address any impacts					
Action			**Person responsible**		**Completion date**

AUTHORISATION			
Name of person completing the form	Nutrition Nurse Specialist	**Signature**	
Validated by (line manager)	Lead for Clinical and Placement Education	**Signature**	