

## Adult Nasogastric Tube Insertion Procedure and Management Policy

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August 2018	August 2023	5.0

### Who should read this document?

All medical or registered Practitioners

### Key Messages

Correct procedural documentation is completed at every stage of the procedure.

Staff engaged in the process of inserting, checking and managing the use of nasogastric tubes are expected to be competent to do so and comply with this policy.

The chest x-ray must only be reviewed by a radiologist, who will confirm the position and make the report available on PACS system.

### Core accountabilities

<b>Owner</b>	Lisa Cripps Lead Nutrition Nurse Specialist
<b>Review</b>	Nutrition Steering Committee
<b>Ratification</b>	Director of Nursing
<b>Dissemination (Raising Awareness)</b>	Lead Nutrition Nurse Specialist
<b>Compliance</b>	Nutrition Steering Committee

### Links to other policies and procedures

Adult Enteral Tube Feeding Policy.  
 Consent to Examination or Treatment Policy.  
 Hand Hygiene Guidelines.  
 Mental Capacity 2005.  
 Ionising Radiation Safety Policy.  
 Restraining Therapies within the Acute Hospital setting for Adult Patients Policy.  
 Radiological confirmation of correct placement of nasogastric tubes in Adults, Children and Neonates for feeding.

#### Version History

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Draft V2.1		Reviewed and amended by Emma Tyler and Julie Morley Nutrition Nurse Specialist Nurses in accordance with NPSA Alert Mar 2011
Draft V2.2	23/08/2011	Approved by the Clinical Governance Steering Group
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Draft V4	May 2017	Reviewed and amended by Lisa Cripps overseen by Patient Safety, Clinical Educators and the Medical Director.
Draft V4.1	July 2017	Minor amendment to action 16, section 6.
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V5.0	Oct 2018	Reviewed by Lisa Cripps. Policy updated to include dual licenced feeding/drainage tubes. Insertion of Radiology SOP with hyperlink, Hyperlink to paediatric NG policy inserted, Update to NG sticker to include dual licenced feeding/drainage tubes.

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**An electronic version of this document is available on Trust Documents.  
 Larger text, Braille and Audio versions can be made available upon request.**

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## 1 Introduction

NHS Improvement published patient safety alert: Nasogastric tube misplacement: continuing risk of death and severe harm 2016. This policy has been modified to comply with the above alert and all preceding documents issued by the NPSA 2005 and 2011.

NHS England published list of Never Events 2013/14 UPDATE states that misplaced naso- or oro-gastric tubes should be avoidable.

This policy and procedure gives information and instruction regarding safe and effective placement and confirmation of tube placement to reduce known risks in line with current Clinical Governance. The document gives guidance to staff in the ongoing management of nasogastric tubes once a tube has been inserted.

This policy is intended for use in the adult patient. The NG policy for Children and Young People can be found on Trustnet. [NG Policy for Children and Young People](#)

## 2 Purpose

University Hospitals Plymouth NHS Trust (UHP) aims to deliver safe and effective care to all its patients

The insertion, tube position check and subsequent management of nasogastric tubes will be safe, effective and comfortable for the patient.

Staff engaged in the process of inserting, checking and managing the use of nasogastric tubes are expected to be competent to do so and comply with this policy.

Nasogastric tubes must be managed in ward environments familiar with their safety critical care, to ensure that they can be checked and monitored safely. Therefore, patients who require nasogastric tubes on wards unfamiliar with them may be moved to ward areas where management of these tubes is commonplace and expertise exists. In the event that a patient cannot be moved for other clinical reasons, provision may be made for staff experienced in the safety critical care of these tubes to assist the ward with the required insertion and management of a patient with a nasogastric tube. All input must be documented in keeping with current trust policy and care documentation.

The purpose of a nasogastric tube is to:

- a) allow drainage of the contents of the stomach when indicated
- b) allow removal of air from the stomach when indicated
- c) Provide a safe access route to the gastrointestinal tract for the administration of fluids, medicines and or nutrients

INDICATION FOR NASOGASTRIC TUBE INSERTION	ACTION	RATIONALE
<p><b><i>Tube used for drainage</i></b></p> <p>Non Functioning Gut (e.g. Paralytic Ileus, Gastrointestinal disease, Gastrointestinal surgery)</p>	<p>Check tube position</p> <p>Request Chest X-Ray (CXR) if there is concern that the gastric aspirate is over 5.5 and/ or the drainage is inadequate</p> <p>leave on free drainage</p> <p>Aspirate as indicated or requested</p>	<p>To avoid aspiration to lungs of accumulated or refluxed gastric contents</p> <p>To allow drainage of accumulated gastric contents and facilitate gastric motility</p>
<p><b><i>Tube used for feeding</i></b></p> <p>Provision of non-oral enteral nutrition and hydration for the patient</p> <p>Administration of non-oral medication</p>	<p>Check tube position before the introduction of any substance into the tube</p> <p>Follow dietetics advice for feeding regime</p>	<p>To confirm the correct placement of the tube in order to avoid accidental introduction of feed to the lungs</p>

### 3 Definitions

Chest X-Ray (CXR) - a radiologically obtained image of the chest to ascertain that the nasogastric tube is in the correct anatomical position.

Continuous Positive Airways Pressure (CPAP) – a non-invasive method of providing respiratory support to patients in specialist ward areas.

Standard Operating Procedure (SOP) a departmental document which sets out expected practice in specified procedures.

Aseptic Non-Touch Technique (ANTT) a method used to prevent contamination of key parts involved in an aseptic procedure.

### 4 Duties

Staff should only undertake this procedure if they are appropriately trained

- Registered Practitioners
- Nurses/Medical staff in training supervised by the above
- All practitioners are personally responsible for updating their practice to maintain competencies and skills at 2 yearly intervals.
- No Locum, Agency or Newly recruited medical or nursing staff are to insert/ confirm tube position / administer any substance via these tubes until training and competency assessment has taken place.
- Accept accountability for their practice.
- Confirmation of Nasogastric tube position via CXR must only be undertaken by a radiologist and the result available on PACS so that ward based medical staff can complete second line check on insertion sticker. [Radiological confirmation of correct placement of Nasogastric Tubes in Adults, Children and Neonates for feeding](#)

The procedures described below are intended to support staff in complying with the stated Trust policy and to ensure care is safe and effective.

Consent for the procedure should be sought under the guidance of the Policy for Consent to Examination and Treatment.

## 5a Risk Assessment & Contraindications

An individual risk assessment should be conducted and documented by a competent person that balances the risks and difficulties of nasogastric tube insertion. The following group of patients are at a high risk of incorrect tube positioning, dislodgement and aspiration and appropriate specialist advice should be taken if the patient has:

- Maxillo-facial disorders, surgery or trauma
- Skull fractures – confirmed or suspected
- Laryngectomy
- Recent radiotherapy to head and neck
- Any disorder of the oesophagus e.g. varices, stricture, surgery.
- Oro-pharyngeal tumours or oro-pharyngeal surgery
- Unstable Cervical Spinal Injuries
- Nasal - Continuous Positive Airway Pressure (C.P.A.P)
- Patient with Endotracheal tubes or Tracheostomy
- Are comatose/semi-comatose
- Are ventilated/sedated
- Have a swallow dysfunction
- Have recurrent retching/vomiting
- Need to be nursed prone
- Gastric bypass surgery
- Caution with clotting abnormalities

This list is not exhaustive.

Oro-gastric positioning may be indicated following head injury or neuro-surgery.

## 5b Nasogastric Tube Selection

There are three types of nasogastric tubes available. Various lengths and lumen diameters are available for adult patients. These have been chosen by UHP following NPSA guidelines 2005.

- Polyvinyl Chloride (PVC) – for short term use up to 30 days (e.g. Ryles tubes) for gastric drainage (and maybe used for feeding in the Critical Care setting for short term only)
  - Polyurethane (PUR) – ENFit compliant Fine Bore Feeding Tubes (FBFT) for the administration of nasogastric feed and medications.
  - Polyurethane (PUR) – ENFit compliant Dual Licensed Feeding and Drainage tubes (DFT) restricted to critical care areas for insertion and stock supplies. Licensed for short term use – drainage 7 days or feeding 28 days. Once feeding is \*established this tube must be changed to fine bore feeding tubes described above. The restrictions of these tubes are set out below:
- NPSA and ENFit compliant Polyurethane Drainage Feeding Tubes (DFT) – for short term use (7 days for drainage and up to 28 days for feeding) tube insertions restricted to **Critical Care areas only**.
  - Stock of these tubes is also restricted to **Critical Care supply areas only**.
  - Care for patients with these tubes in situ must include all elements set out in the current Adult Nasogastric Tube Insertion Procedure & Management Policy
  - Once enteral feeding is \*established i.e. 4 hourly nasogastric aspirates obtained are < 250mls and this continues for 48hours the Drainage Feeding Tube **MUST** be changed to ENFit compliant Fine Bore feeding tube
  - Patients may only be sent to general ward areas with these tubes in situ if nasogastric aspirate volumes indicate reduced gastric motility i.e. aspirated volumes consistently >250mls over 4 hours.
  - The DFT's are not an alternative to fine bore nasogastric feeding tubes which must remain the product of choice for established nasogastric enteral tube feeding.
  - Critical Care Electronic patient records (Innovian) must indicate clearly what tube type is inserted into the patient, anticipated tube replacement date, include all safety critical insertion information set out by the NPSA and handed over to ward based nursing staff upon discharge from critical care areas.
  - Any adverse events relating to the use of these tubes must be reported via the DATIX

systems, making the tube type explicitly clear on the report.

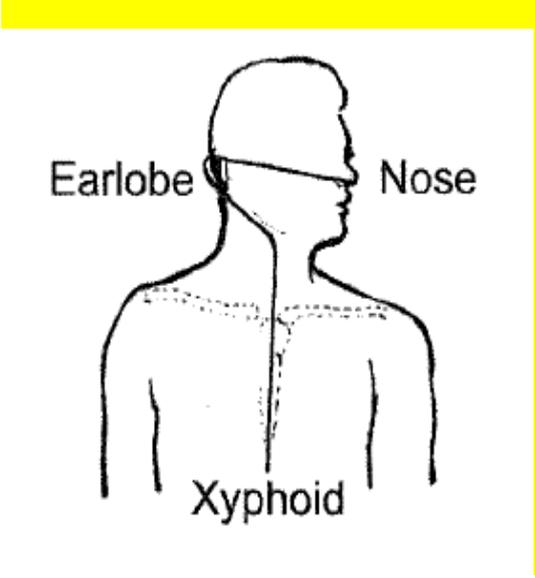
**5c Procedure for the Insertion of a Nasogastric Tube for the Adult Patient**

**Equipment required:**

1. Clinically clean tray
2. Fully Radio-opaque Nasogastric tube which is appropriate for its designated use
3. Tissues
4. Tape to secure e.g. Nasofix
5. 60ml purple enteral syringe
6. pH indicator strips (CE marked for human aspirate)
7. Disposable bowl
8. Spigot/Drainage Bag (if necessary)
9. Glass of water, straw (if safe to swallow)
10. Mouth care equipment (if unsafe to swallow)
11. Non sterile gloves and apron
12. UHP Record of Insertion of Nasogastric Tube Sticker (Appendix C)
13. UHP Nasogastric Tube Position Record Form – Appendix D

	<b>ACTION</b>	<b>RATIONALE</b>	<b>EVIDENCE</b>
1	<p>Before a decision is made to insert a nasogastric tube, an assessment is undertaken to identify the reason for the nasogastric tube insertion:</p> <ul style="list-style-type: none"> <li>a) for drainage only</li> <li>b) for drainage and possible feeding (Critical Care ONLY)</li> <li>c) for feeding and medication</li> </ul> <p>The rationale for any decisions is recorded in the patient's medical notes, including purpose and type of nasogastric tube to be inserted.</p> <p>The responsibility for this decision lies with the Consultant in charge of the patient's care</p>	<p>To ensure that the nasogastric tube insertion is necessary, avoiding putting the patient through an unnecessary procedure with potential complications.</p>	<p>NPSA (2011)</p> <p>Internal Safety Bulletin (2013)</p> <p>NNNG (2012)</p>

2	<p>Check patient ID and explain the procedure to the patient.</p> <p>Ensure patient is in agreement with the procedure and that verbal/informed consent is gained and documented. If patient is unable to consent then capacity must be established and action is in best interests.</p>	<p>To obtain the patient's consent and co-operation.</p> <p>To document consent.</p>	<p>Price (2009)</p> <p>Curtis K (2013)</p> <p>Dougherty &amp; Lister (2011)</p> <p>Mental Capacity Act (2005)</p>
3	<p>The patient should be monitored closely throughout the procedure by nursing staff.</p> <p>In the acute setting the procedure should be carried out in a clinical area which has access to emergency equipment in full working order.</p> <p>In the community setting a patient specific assessment of the risks versus benefits of the use of a nasogastric tube should be made.</p>	<p>Early detection of cyanosis or bradycardia will prevent further deterioration of the patient's condition throughout the procedure.</p> <p>To enable medical and nursing staff to deal with serious complications should they occur.</p> <p>To decide if benefits outweigh risks</p>	<p>Mensforth et al (2001)</p>
4	<p>Assist the adult patient to sit in a supported upright position, ensuring the patient's head and shoulders are well supported by pillows.</p> <p>If the patient is unconscious or semi-conscious, place into a safe position by laying the patient on their side.</p>	<p>To allow for easy passage of the tube. This position allows easy swallowing and ensures the epiglottis is not obstructing the oesophagus.</p> <p>To ensure correct passage and position of the NG tube.</p>	<p>NNNG (2012)</p> <p>Dougherty &amp; Lister (2011)</p>
5	<p>Wash hands with soap and water, rinse and dry well. Put on gloves/apron. Assemble the equipment required.</p>	<p>To minimise cross infection.</p>	<p>NICE (2006)</p> <p>UHP Hand washing and PPE policy</p>

6	<p>Place the tip of the tube on the patient's nose, extend the tube up to the top of the patient's ear and follow the contour around behind the ear. Then follow the tract the tube will take to the xiphisternum and note this place using the cm markings on the tube.</p> 	<p>To ensure that enough tube has been passed down through the oesophagus to reach the stomach</p>	<p>NPSA (2011) NNNG (2012)  Merck Serono (2009)</p>
7	<p>Examine the patient's nostrils. If necessary ask the patient to blow their nose first.</p>	<p>To identify any obstructions liable to prevent insertion of tube.</p>	<p>NNNG (2012)</p>
8	<p>If patients are unable to swallow carry out mouth care prior to inserting the tube.</p>	<p>If the patient has dysphagia (loss of swallow reflex) they will be unable to swallow water safely and should not be asked to drink whilst tube is inserted</p>	<p>Pulling R (1992)</p>
9	<p>Lubricate proximal end of tube with water.</p>	<p>To assist passage through the nasopharynx.</p>	<p>Mensforth and Nightingale (2001)</p>

10	<p>Insert the tube into the agreed nostril to the back of the nose, along the floor of the nose to the nasopharynx.</p> <p>If any obstruction is felt, withdraw the tube and try again in a slightly different direction or use the other nostril.</p>	<p>To facilitate the passage of the tube by following the natural anatomy of the nose.</p>	<p>NNNG (2012)</p>
11	<p>As the tube passes down into the nasopharynx ask the patient to swallow water via a straw.</p> <p>Try a dry swallow if unable to safely drink.</p> <p><b>(If there is doubt of a patients' ability to swallow safely a Speech and Language assessment may be necessary).</b></p>	<p>A swallowing action closes the glottis enabling the tube to pass into the oesophagus.</p>	<p>NNNG (2012)</p>
12	<p>Advance the tube through the pharynx as the patient swallows until the predetermined mark on the tube has been reached.</p> <p>If the patient complains of excessive discomfort withdraw tube and re-attempt insertion.</p> <p>If the patient shows signs of distress (e.g. gasping, coughing or cyanosis) remove the tube immediately. If respiratory distress does not resolve with removal of the tube abandon the procedure and inform medical staff.</p>	<p>To facilitate the passage of the tube to the stomach and to be aware of signs incorrect tube placement.</p>	<p>Colagiovanni (1999)</p> <p>Gharib (1996)</p>
13	<p>pH testing is used as the <b>first line test method</b>. Each test is documented on the UHP Nasogastric Tube Position record plan (Appendix D), which is kept at the patient's bedside.</p> <p><b>Nasogastric tubes are NOT flushed, nor any liquid/feed introduced through the tube following initial placement, until the tube tip is confirmed by pH testing or x-ray, to be in the stomach.</b></p>	<p>To ensure that the tube is in the stomach</p>	<p>NPSA (2005)</p> <p>NPSA (2011)</p>

13a	<p>Using gentle suction, aspirate a sample of 2-5mls fluid (<b>5mls Critical Care</b>) using a 60ml purple enteral syringe.</p> <p>Place the aspirate onto pH paper (CE marked for human aspirate) and check the reading.</p> <p><b>A pH of between 0 and 5.5 indicates a reading deemed to be within a safe range.</b></p> <p>If it is not possible to obtain an aspirate from the nasogastric tube, please see Trouble shooting section</p> <p>If the aspirate gives a result of a pH greater than 5.5 see Trouble Shooting section 7.9</p>	<p>Stomach contents are acidic and have a pH around 3-4. However the National Patient Safety Agency state that a pH reading of 5.5 or below is acceptable</p>	NPSA (2011)
13b	<p>If still unable to gain aspirate or if the aspirate is still above 5.5 then <b>DO NOT USE THE TUBE</b> and consult medical staff. Document all techniques that have been used to try to obtain aspirate. Document the medical decision and management plan for that individual patient.</p> <p>If there is a clinical concern regarding the correct positioning of a Naso-Gastric tube inserted for gastric decompression a CXR should be performed to confirm position, regardless if the pH is &lt; 5.5</p>	<p>CXR may be needed to check position if it is felt to be safe to continue with the attempt to site a nasogastric tube</p> <p>To highlight risks with misplacement in oesophagus that may not be picked up with pH of &lt; 5.5</p>	PHNT Internal Safety Bulletin (2013)
14	<p>Complete a UHP Record of Insertion of Nasogastric Tube sticker (Appendix C) and stick in current entry of the patients medical notes.</p> <p>If the decision is to proceed to a CXR to verify the position of a naso-gastric tube, remember it is only valid at the time it is taken</p>	<p>To ensure adherence to NHS England guidance.</p>	NPSA (2011)
15	<p>X-ray is used only as a <b>second line test</b></p>	<p>To ensure the naso-gastric tube is</p>	NPSA (2011)

15	<p>when:</p> <ul style="list-style-type: none"> <li>• a gastric aspirate is unobtainable and/or</li> <li>• a gastric aspirate has a pH of 6 or greater</li> </ul> <p>and/or</p> <ul style="list-style-type: none"> <li>• where tube is used for drainage and position has been felt to be sub-optimal</li> </ul> <p>Out of hours request for radiological imaging is restricted.</p> <p>Any decisions made should be recorded in the patient's medical notes.</p> <p>X-ray requests must state that the purpose of the x-ray is to establish the position of the nasogastric tube, and the reason for the request (as above)</p> <p><b>The chest x-ray must only be reviewed by a radiologist, who will confirm the position and make the report available on PACS system.</b>  <a href="#">Trust Radiology SOP</a> (The only exception to this is within critical care areas where a departmental policy agreement exists)  Documentation of the tube placement checking process should include:</p> <ul style="list-style-type: none"> <li>• Any x-ray viewed was the most current x-ray for the correct patient.</li> <li>• The four visual points of CXR interpretation are noted and confirmed using the UHP Nasogastric tube insertion sticker</li> <li>• Clear instructions as to required actions.</li> </ul> <p><b>Any tubes identified to be in the lung are removed as soon as it is practically possible to do so.</b></p>	<p>adequately positioned in the stomach</p> <p>To ensure that sufficient knowledge/expertise is available to interpret chest x-ray</p> <p>To reduce the risk of misinterpretation of the chest x-ray.</p> <p>To ensure inappropriate radiation is not given</p> <p>To ensure that the radiographer adjusts the exposure of the x-ray.</p> <p>To prevent potential errors of staff confirming tube position out of hours.</p> <p>To avoid a Serious Untoward Incident and patient harm</p>	<p>PHNT Internal Safety Bulletin (2013)</p> <p>Radiation Policy</p> <p>NPSA (2016)</p> <p>NPSA (2011)</p> <p>NPSA (2011)</p>
16	<p>If a guide-wire is present it should be removed when the correct position has been confirmed. This is done by flushing 10 mls of freshly drawn tap water through the guide-wire port and then</p>	<p>Withdrawal of the guide-wire without the use of lubricant can cause the tube to be misplaced. Flushing</p>	<p>Copra 2013</p>

	gently rotating the wire and withdraw it from the tube. <b>NB</b> Guide wires must <b>NOT</b> be reintroduced into the nasogastric tube whilst the tube is inside the patient under any circumstances.	with water activates the water soluble lubricant.  To prevent accidental perforation of the tube/patient.	
17	If a CXR has been performed the image must be checked by a radiologist following the departmental SOP who will make the result available on PACS. The radiology SOP can be found on Trustnet. Ward medical staff must complete the second section of the UHP record of insertion of the nasogastric tube' sticker (Appendix C) which has been placed in patient's medical notes previously.	To provide a record of care.  To identify that safe procedures have been carried out.	NMC 2002a
18	Once position has been confirmed and Nasogastric Tube is safe to use, commence the adult UHP Nasogastric Tube Position Record Appendix D <a href="#">Nasogastric Tube Position Record</a>	To provide an accurate record of ongoing care	NMC2002a

## 5d Post Insertion Management of a Patient with a Nasogastric Tube Inserted.

7.1	<p><b>Subsequent verification of Nasogastric Tube position</b></p> <p>Serious adverse effects on the patient's condition may be associated with the suboptimal positioning of the tube once inserted. The patient must be observed for adverse signs and symptoms which may indicate tube misplacement or suboptimal position.</p> <ul style="list-style-type: none"> <li>• Following each changeover of nursing shift</li> <li>• Before administering medications, fluid or feed</li> <li>• Once daily during continuous feeds</li> <li>• Once daily to confirm position when for drainage</li> <li>• When there is suggestion of tube displacement e.g. change in tube length, patient comfort</li> <li>• After severe episodes of coughing, retching or vomiting</li> <li>• Any new or unexplained respiratory symptoms or distress</li> <li>• After nasopharyngeal, endotracheal or tracheostomy tube suctioning</li> <li>• If the patient complains of discomfort</li> <li>• If the patient experiences feed reflux into the mouth</li> <li>• If there is any doubt the tube may not be in the stomach</li> </ul>
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	<p>Prokinetics can affect the ability to gain an aspirate due to their effect of increasing in stomach emptying. PPI's inhibit gastric acid secretion.</p>
7.2	<p><b>Prevention of Infection</b></p> <p>Ensure hand washing procedures are followed at all times</p> <p>Ensure ANTT principles are followed at all times</p> <p>Non-sterile gloves and apron should be worn.</p> <p>Check packaging on all consumables are intact and in date.</p> <p>Feed can be hung for a maximum of 24 hours and ensure feed and administration sets are labelled with date and time.</p> <p>Enteral syringes (purple) are single use items and should be discarded after each use</p>
7.3	<p><b>Flushing</b></p> <p>Flushing should be performed at the Nasogastric tube ports, not at the side port of a giving set.</p> <p>Freshly drawn drinking water should be used and the minimum amount of 30mls. Check dieticians recommendations as this may vary depending on patients fluid requirements</p> <p>Flushing should take place after each bottle of feed, after a rest period, if the feed is temporarily stopped &amp; before, in-between and after each medication</p> <p>For immuno-suppressed patients sterile water should be used to flush the Nasogastric Tube</p>
7.4	<p><b>Nasogastric Securement Devices</b></p> <p>Consider cleaning the nose/cheek with an alcohol swab prior to securing the tube to remove grease from the skin, increasing the chance of the tube being successfully secured.</p> <p>Secure the tube to the nostril and cheek with appropriate tape and/or fixation device.</p> <p>See separate standard operating procedure if a nasal bridle is felt to be required for repeated pulling out of Nasogastric tube.</p>
7.5	<p><b>Administration of Enteral feed and medicines via a Nasogastric Tube</b></p> <p>Please see Adult Enteral Tube Feeding Guidelines (unable to hyperlink at present)</p>
7.6	<p><b>Nasal skin Integrity and patient comfort</b></p>

	<p>Daily or more frequent inspection for nasal erosion is required. Patients with a nasogastric tube for a prolonged period of time are especially at risk.</p> <p>Change the site of the securing device as required.</p> <p>Consider removing the Nasogastric tube and replacing in the other nostril.</p>
7.7	<p><b>Hand mittens</b></p> <p>Please see Restraining Therapies within the Acute Hospital setting for Adult Patients Policy</p>
7.8	<p><b>Mouth Care</b></p> <p>It is essential to provide good oral hygiene at regular intervals whilst the nasogastric tube is in situ.</p> <p>Offer water to rinse the mouth regularly if nil by mouth.</p> <p>Brushing teeth is important and should be encouraged at least twice daily.</p> <p>Assist the patient if needed.</p>
7.9	<p><b>Troubleshooting</b></p> <p><b>Warning</b></p> <p><b>Bronchial secretions can read pH 6 or greater.</b></p> <p><b>For NGT for drainage- A recording of pH 5.5 does not guarantee the tube is not in the Oesophagus</b></p> <p><b>Unable to obtain a pH of 5.5 or below.</b></p> <p>Patients receiving the following drugs may have a high gastric pH:</p> <p>H2 Antagonists e.g. ranitidine</p> <p>Proton pump inhibitors e.g. omeprazole</p> <p>The gastric aspirate obtained from these patients therefore, may be &gt; 6, try to delay the aspirate check until as long after the administration of drug.</p> <p>If patient's swallow is intact and not NBM, give acidic drink e.g. Pineapple or Blackcurrant. Retry after 20 minutes.</p> <p>These patients therefore may require repeat aspirate tests observing times of drug administration. If pH still &gt;6 an initial chest x-ray may be appropriate to confirm gastric placement</p> <p><b>If it is not possible to obtain an aspirate try the following:</b></p> <p>Give mouth care to patients who are nil by mouth to stimulate gastric secretion.</p> <p>If the patient is able to swallow ask them to drink a small amount of water as it adds fluid to the stomach.</p>

	<p>The NG tube may be caught in the stomach wall, flush the tube with 10-20mls of air to dislodge the tube.</p> <p>Turn the patient on their left side to improves position of stomach contents and retry aspiration after 20 – 60 minutes</p>
7.10	<p><b>Removal</b></p> <p>Explain the procedure to the patient and obtain their informed verbal consent.</p> <p>Provide tissues for the patient to clean or blow their nose after removal of the tube.</p> <p>Wash hands and put on gloves and apron.</p> <p>Take off the fixation tape and gently withdraw through the nostril.</p> <p>Ensure the tube is intact and document removal.</p>
7.11	<p><b>MDT risk assessment for discharge with Enteral feeding via a Fine Bore Feeding Tube</b></p> <p>A full multidisciplinary supported risk assessment is made and documented before a patient with a nasogastric tube is discharged from acute care to the community.</p> <p>(See section 11 of the Adult Enteral Tube Feeding Guidelines)</p>
7.12	<p><b>Patient Education &amp; discharge</b></p> <p>Please see Adult Enteral Tube Feeding Guidelines</p>

## 5e Training Requirements

All staff involved with Nasogastric tube insertion or/and management require training. Department/Ward managers should nominate a suitable registered practitioner to undertake the training and assessment for Adult Nasogastric Tube insertion and management. This nominated practitioner will then attend the Adult Nasogastric Tube Insertion and Management Train the Trainer session. After successful completion of the Train the Trainer requirements, the nominated person then cascades the training and assesses competence of the areas staff.

Evidence of training should be recorded on OLM. A record of competency should be recorded on Health Roster. Paper evidence of competency assessment should be maintained locally for departmental information and in case competency of staff needs to be scrutinised or inspected.

Once competence has been obtained, insertion and management of adult nasogastric tubes updates via e-learning are needed 2 yearly and recorded on ESR.

## **6 Overall Responsibility for the Document**

The Nutrition Steering Committee.

## **7 Consultation and Ratification**

The design and process of review and revision of this policy will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the Nutrition Steering Committee and ratified by the Director.

Non-significant amendments to this document may be made, under delegated authority from the Director, by the nominated owner. These must be ratified by the Director.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

## **8 Dissemination and Implementation**

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner will be responsible for agreeing the training requirements associated with the newly ratified document with the named Director and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

## **9 Monitoring Compliance and Effectiveness**

This policy will be monitored through:

A monthly review of patients with NG tubes by Matron/Ward Manager or nutrition Link Nurses; this must be carried out by completion of a monthly audit via Meridian

The monitoring will be performed monthly, any shortfalls will be addressed by the departmental manager/ward Matron

The results will be reported to the Nutrition Steering Committee.

Quarterly review meeting with key stakeholders e.g Radiology, Patient Safety Lead, Nutrition CNS

Incidents related to NG tubes will be reviewed via Datix by Patient Safety Team and when appropriate Rachel Allen and Lisa Cripps

Ongoing education with support from the Clinical Education department

Medical staff to have training as mandatory training.

The Information Governance Team will ensure that old versions of the policy are archived in the archive master file. Access to archived documents will be through the Records Strategy and Archive Manager.

The Information Governance Team will issue the policy numbers and maintain an index that will include the document's title, policy number and version, owner, issue date and next review date.

The approvals are indicated by the front sheet of the document as is the version control.

## 10 References and Associated Documentation

Bayes, R.J., Kruse, J.A., (1992) Nasogastric and nasoenteric intubation. *Critical Care Clinics*. 8(4), 865 – 867.

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National Patient Safety Agency (2004) Advice to the NHS on reducing harm caused by the misplacement of naso-gastric feeding tubes. [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

National Patient Safety Agency (2011) Advice to the NHS on reducing harm caused by the misplacement of naso-gastric feeding tubes. [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

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National Nurses Nutrition Group (NNNG 2012) Good Practice Guideline: Safe Insertion of Nasogastric Feeding Tubes in Adults [www.nnng.org.uk](http://www.nnng.org.uk)

(NMC) Nursing and Midwifery Council. (2002a) Guidelines for records and record keeping. NMC London.

Price, B. (1989) Nasogastric intubation. Nursing Times. Vol 85, No. 13, p 50-52.

Pulling, R. (1992) The Right Place. The Canadian Nurse 88 (2): 29 – 30 Feb.

Rollins, H. (1997) A nose for trouble. Nursing Times. Vol 93, No.49, P66 – 67.

Dissemination Plan			
Document Title			
Date Finalised			
Previous Documents			
Action to retrieve old copies			
Dissemination Plan			
Recipient(s)	When	How	Responsibility
All Trust staff		Vital Signs	Information Governance Team

Review Checklist		
<b>Title</b>	Is the title clear and unambiguous?	
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	
	Does the style & format comply?	
<b>Rationale</b>	Are reasons for development of the document stated?	
<b>Development Process</b>	Is the method described in brief?	
	Are people involved in the development identified?	
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	
	Is there evidence of consultation with stakeholders and users?	
<b>Content</b>	Is the objective of the document clear?	
	Is the target population clear and unambiguous?	
	Are the intended outcomes described?	
	Are the statements clear and unambiguous?	
<b>Evidence Base</b>	Is the type of evidence to support the document identified explicitly?	
	Are key references cited and in full?	
	Are supporting documents referenced?	
<b>Approval</b>	Does the document identify which committee/group will review it?	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	
	Does the document identify which Executive Director will ratify it?	
<b>Dissemination &amp; Implementation</b>	Is there an outline/plan to identify how this will be done?	
	Does the plan include the necessary training/support to ensure compliance?	
<b>Document Control</b>	Does the document identify where it will be held?	
	Have archiving arrangements for superseded documents been addressed?	
<b>Monitoring Compliance &amp; Effectiveness</b>	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	
	Is there a plan to review or audit compliance with the document?	
<b>Review Date</b>	Is the review date identified?	
	Is the frequency of review identified? If so is it acceptable?	
<b>Overall Responsibility</b>	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	

<b>Core Information</b>	
<b>Date</b>	
<b>Title</b>	
<b>What are the aims, objectives &amp; projected outcomes?</b>	
<b>Scope of the assessment</b>	
<b>Collecting data</b>	
<b>Race</b>	
<b>Religion</b>	
<b>Disability</b>	
<b>Sex</b>	
<b>Gender Identity</b>	
<b>Sexual Orientation</b>	
<b>Age</b>	
<b>Socio-Economic</b>	
<b>Human Rights</b>	
<b>What are the overall trends/patterns in the above data?</b>	
<b>Specific issues and data gaps that may need to be addressed through consultation or further research</b>	

<b>Involving and consulting stakeholders</b>				
<b>Internal involvement and consultation</b>				
<b>External involvement and consultation</b>				
<b>Impact Assessment</b>				
<b>Overall assessment and analysis of the evidence</b>				
<b>Action Plan</b>				
<b>Action</b>	<b>Owner</b>	<b>Risks</b>	<b>Completion Date</b>	<b>Progress update</b>

This document does not require Equalities and Human Rights Impact Assessment to be completed.