Insertion and Management of Nasogastric and Orogastric Tubes in Children and Neonates

Policy and Procedures

Approved By: Policy and Guideline Committee

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Supersedes: Children’s elements formerly incorporated in B39/2005 (now adults only)

Trust Lead: Carol Stevenson

Board Director Lead: Claire Agnew

Date of Latest Approval: 17 November 2017 – Policy and Guideline Committee

Next Review Date: November 2020

NB: Paper copies of this document may not be most recent version. The definitive version is held in the policy and guidelines library
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Introduction</td>
<td>2</td>
</tr>
<tr>
<td>2 Decision Tree Flow chart</td>
<td>5</td>
</tr>
<tr>
<td>3 Policy Scope</td>
<td>6</td>
</tr>
<tr>
<td>4 Definitions &amp; abbreviations</td>
<td>6</td>
</tr>
<tr>
<td>5 Roles and Responsibilities</td>
<td>7</td>
</tr>
<tr>
<td>6 Policy Summary</td>
<td>11</td>
</tr>
<tr>
<td>7 Education and Training</td>
<td>11</td>
</tr>
<tr>
<td>8 Process for Monitoring Compliance</td>
<td>12</td>
</tr>
<tr>
<td>9 Equality Impact Assessment</td>
<td>12</td>
</tr>
<tr>
<td>10 Supporting References, Evidence Base and Related Policies</td>
<td>13</td>
</tr>
<tr>
<td>11 Process for Version Control, Document Archiving and Review</td>
<td>14</td>
</tr>
</tbody>
</table>

### Appendices:

1. Equipment used in the Insertion of a Nasogastric Tube in Infants & Children
2. Procedure for the Insertion & Removal of a Nasogastric Tube for Infants & Children
3. Procedure for the Confirmation of an Nasogastric Tube in Infants & Children
4. Ongoing Care of a Nasogastric Tube in Infants & Children
5. Tube Insertion Documentation Sticker

## REVIEW DATES AND DETAILS OF CHANGES MADE DURING REVIEW

1. Removal of Adult References to create a Paediatric Only Policy
2. Removal of Appendix 8 in line with NPSA RRR ‘Never flush’ RRR001/2012
3. Removal of Dietetic enteral feed prescription in care plan
5. Addition of trainee statement

## KEY WORDS

NG, ng, nasogastric, naso-gastric, OG – Orogastric, nasojejunal, naso-jejunal, enteral, feeding tube
1. INTRODUCTION AND OVERVIEW

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust policy and procedures for the insertion and on-going care of nasogastric tubes (NGT) for feeding, administration of medicines and gastric drainage in Infants and children.

1.2 The aim of a NGT is to:

1.2.1 Allow drainage of the contents of the stomach when indicated.

1.2.2 Allow removal of air from the stomach when indicated.

1.2.3 Provide a safe access route to the gastrointestinal tract for the safe administration of fluids, drugs and / or nutrients.

1.2.4 Infants & Children who either are unable to take any nutrition orally or who are unable to take sufficient nutrition orally, but in whom the gastrointestinal tract is functioning, may be fed by an NGT

Benefits include:

- It is quick and easy to establish
- Minimally invasive
- Parents, Carers and Mature Patients can be taught to pass the tube

Risks and Drawbacks associated with NG feeding include:

- The insertion procedure is traumatic for the majority of children
- The tube is noticeable
- Babies and Young Children are likely to pull out the tube making regular re-insertion necessary
- Aspiration – if the tube is placed incorrectly
- Increased risk of gastroesophageal reflux with prolonged use
- Damage to the skin on the face

1.3 Nasogastric tube feeding in infants and children is particularly useful in the short term, and when it is necessary to avoid a surgical procedure to insert a gastrostomy device. However, in the long term gastrostomy feeding may be more suitable.

1.3 It is important to maintain health and prevent deterioration in nutritional status as this may impair the ability to provide treatment. Nutritional support should be actively considered and planned for during treatment planning and Paediatric Dieticians should be involved if any concern is identified.

1.4 All patients must have their nutritional status assessed using the Paediatric Yorkhill Malnutrition Score (PYMS). (Paediatric Assessment Tool). Neonatal patients do not require this.
1.5 UHL has approved the British Association for Parenteral and Enteral Nutrition (BAPEN) guidelines for the “Administration of medications via enteral feeding tubes” which are outlined in the BAPEN Guidelines.

For guidance on the administration of NJ feeds in children please refer to UHL guideline C90/2016. Further guidance regarding NJ management is currently under development.
2. DECISION TREE & RISK ASSESSMENT FOR NG TUBE PLACEMENT CHECKS IN INFANTS AND CHILDREN

- Before a decision is made to insert an NG tube an assessment MUST be made to identify if NG feeding is appropriate for the patient.
- Before passing tube you must estimate NEX measurement (place exit port of tube at tip of nose, extend tube to earlobe and then to xiphisternum) confirm and document.
- In neonates you must estimate NEMU measurement (place port of tube at tip of nose, extend to the earlobe and then to the midpoint between the sternum and umbilicus).
- You must ensure that a fully radio-opaque NG tube for feeding is passed.
- Aspirate using the correct size/type of enteral syringe.
- Secure the tube safely with hypoallergenic tape & hydrocolloid dressing.
- You MUST NOT use the tube for feeding until the position has been confirmed with aspirate.
- If confirming a tube already in use—Gently insert 1-6ml air to free feeding ports of mucosa, debris, water and feed (as per procedure).

**YES**

**ASPIRATE OBTAINED 0.2-1ML**

**DO NOT FEED**
- Try these techniques to help gain aspirate:
  - On initial insertion—advance/retract tube aspirating at 1cm intervals
  - If possible, reposition child on their left side
  - If possible, gently change child’s position or encourage activity to stimulate gastric secretion
  - If appropriate—offer oral fluids or a dummy to infants
  - Give mouth care to patients who are nil-by-mouth
  - Wait 15-30 minutes before aspirating again

**IF STILL UNABLE TO OBTAIN ASPIRATE**
- Consider that the tube may be blocked or misplaced
- Discuss with more experienced staff
- Consider removing or replacing the tube unless contra-indicated (e.g. after gastric surgery)
- Document decisions and rationale

**YES**

**PH 6.0 OR ABOVE**

**ASPIRATE OBTAINED 0.2-1ML**

**NO**

**PH REMAINS 6.0 OR ABOVE**

**NO**

**IF PH REMAINS 6.0 OR ABOVE DO NOT FEED**

- Consider—
  - Replacing or re-passing tube
  - Reviewing medication
  - Refer to senior medical team & dietician
  - Review trend of previous PH values
  - Amount and type of aspirate obtained
  - Is child showing signs of respiratory distress now or during previous feeds

**SPECIAL CONSIDERATIONS**
- Reduced conscious level/GAG reflex
- Mechanical ventilation
- Chronic cough
- Difficulty experienced when passing tube

**COMPETENT CLINICIAN (WITH EVIDENCE OF TRAINING) TO DOCUMENT CONFIRMATION OF NG TUBE POSITION IN STOMACH**

**IF UNSURE DO NOT FEED or USE TUBE CALL FOR SENIOR MEDICAL HELP**

**Before a Decision is Made to Insert an NG Tube an Assessment MUST be Made to Identify if NG Feeding is Appropriate for the Patient.**

BEFORE PASSING TUBE YOU MUST ESTIMATE NEX MEASUREMENT (PLACE EXIT PORT OF TUBE AT TIP OF NOSE, EXTEND TUBE TO EARLOBE AND THEN TO XIPHISTERNUM) CONFIRM AND DOCUMENT.

IN NEONATES YOU MUST ESTIMATE NEMU MEASUREMENT (PLACE PORT OF TUBE AT TIP OF NOSE, EXTEND TO THE EARLOBE AND THEN TO THE MIDPOINT BETWEEN THE STERNUM AND UMBILICUS).

YOU MUST BE AWARE THAT SOME MEDICATIONS CAN ELEVATE CAN PH READINGS—it may therefore take an hour post-medication for gastric PH to rise.
3. POLICY SCOPE

3.1 This policy and its supporting procedures aim to support staff in the ongoing management of NGT’s/OGT’s in all babies, children and young people by:

1. Providing clear directives for the safe and effective placement of NGT in all patients

2. Providing clear directives for the safe position checking NGT’s

3. Ensuring NG/OG feeding or NG drainage is incorporated into the patient’s care plan.

3.2 This policy applies to all healthcare staff employed by UHL (including those on bank, agency and honorary contracts) who insert and/or care for babies, children or young people with a NGT/OGT.

3.3 UHL is a teaching hospital and provides placement or work based learning for Pre-registration students such as Medicine, Nursing, Midwifery, Paramedic, Radiography, Physiotherapy, Occupational Therapy and Pharmacy and Trainees in the workplace such as Assistant Practitioners and Nursing Associates. This policy applies to these learners in the following circumstances:

a) If paediatric or neonatal naso-gastric tube insertion and/or feeding is a specific competency requirement of their placement or programme then the pre-registration student / trainee is able to perform the skill under direct supervision of their mentor / supervisor once they have received the relevant underpinning theory and passed a simulated practice

b) If paediatric or neonatal naso-gastric tube insertion and/or feeding is not a specific competency requirement of their placement or programme then the pre-registration student / trainee must only participate in the process as an observer.

3.4 This Policy applies to Parents or Carers i.e. those individuals who have undertaken daily care regimes for the child on a routine basis and have been appropriately trained by a competent registered practitioner.

4. Definitions and Abbreviations

EN – enteral nutrition
HENS – Home Enteral Nutrition Service (Community Dietitians)
MaxFax - Maxillo-facial
NEMU- Nose to Earlobe to a point halfway between the Xiphisternum and the Umbilicus
NEX – Nose to Earlobe to Xiphisternum
NG - Nasogastric tube
NJ - Nasojejunal tube
NSN - Nutrition Specialist Nurse
OG - Orogastric is defined as the passage of an orogastric tube via the mouth into the stomach

5. ROLES AND RESPONSIBILITIES

It is the responsibility of all staff to ensure they are competent to perform skills they can reasonably be expected to perform as part of their specific job role and in relation to general, interventional or medical care.

Staff must not undertake a task they are not competent to perform unless they are being taught and supervised by a competent professional.

It is the responsibility of all staff to ensure the necessary care is delivered in a timely way. If they are not competent to deliver the care themselves they must communicate this to a competent individual who is in a position to deliver the care. Depending on the level of care required this may be a colleague within their department or medical staff.

For guideline specific training requirements please see section 7 of this guideline

5.1 Executive Lead
Head of Children’s Services and Head of Nursing

5.2 Senior Clinical Management Teams
CMG Heads of Nursing, Deputy Heads of Nursing and Matrons alongside & Head of Service are responsible for ensuring CMG clinical teams are trained and competent and are aware and familiar with this policy

5.3 Medical Staff / Competent Clinician is responsible for;

a) The medical staff/ competent clinician is responsible for identifying suitable patients for NGT insertion and referring on those that are not suitable to appropriate teams.

b) Delaying the placement of the tube if requested out of hours and there is not sufficient experienced support available to accurately confirm nasogastric tube placement at ward level e.g. Staff are not confident / competent in PH testing of NG tube placement.

c) Ensuring the decision to commence nasogastric feeding is based on the patient’s nutritional status and goals of overall therapy and the decision is documented on the NG care plan or medical notes as per NPSA Guidance.

d) Ensuring that the NGT is not used unless pH gastric placement is confirmed

e) Ensuring that the NGT is not used unless placement is confirmed on an abdominal plain film X-ray.

f) Ensuring that when requesting a Xray for NGT gastric placement confirmation that the X-ray request forms clearly state that the purpose of the x-ray is to establish the position of the nasogastric tube for the purpose of feeding.(NPSA)

g) It is mandatory that the medical staff responsible for the patient be able to provide the radiographer with the tube measurement marker number in cms (tube measurement will be recorded on the insertion sticker which is placed in the medical notes), outcome of an attempted gastric aspiration via the nasogastric
tube, and confirmation that the guidewire is not in situ. Failure to do so may result in the CXR request being denied.

h) In the event that the CXR will not be reviewed by a radiologist for >1 week the competent clinician is responsible for;

I. Contacting the 24hour on-call radiologist SPR level or above if they are unable to confirm placement for an immediate report or expert advice.

II. Documenting the gastric placement checking process as 2. Decision tree page 4

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

IV. How gastric placement was interpreted

V. Clear instructions as to any required actions

VI. Any tubes identified to be in the lung are removed **immediately**, whether in the x-ray department or clinical area.

VII. It is the responsibility of the medical team caring for the patient to refer to if they experience on-going issues with pH checking NGT.

5.4 Radiologists/ Radiology Advanced Practitioners

When the radiologist/ Radiology Advanced Practitioner reports the placement film, he or she must document the position of the nasogastric tube and tip.

5.5 Senior CMG nurses

Heads and Deputy Heads of Nursing and Matrons are responsible for ensuring adequate staffing levels of competent nurses within their clinical areas.

5.6 Ward Sisters / Charge Nurses

Are responsible for ensuring development on the ward or unit of appropriate numbers of competent staff and responsible for on-going monitoring of the quality of the NG/OG techniques used within their clinical areas

5.7 Registered Nurses are responsible for;

a) Are responsible for the individual care of patients requiring artificial nutrition.

b) Ensuring that the care they provide to these patient groups is in line with UHL policies and procedures and are appropriately trained.

c) To administer prescribed NG/OG feed and associated medications as prescribed and as per this policy.

d) To administer prescribed feed and water flushes as per the Dietician’s regime and as per this policy’s instructions. In Neonatal unit flushes are not required.

e) To liaise with the Home Enteral Nutrition Service (HENS) Dietitians prior to patient discharge. In Neonatal unit the neonatal Outreach team must be contacted.
f) Ensuring NGT / OG insertion, initial and ongoing position checks and care are provided as detailed in this Policy and Procedures and the tube is not used unless gastric placement is confirmed.

g) Following this policy when inserting an NGT / OG and / or caring for a patient with a NGT / OG.

h) Delaying the placement of the tube if requested out of hours and there is not sufficient experienced support available to accurately confirm nasogastric tube placement at ward level e.g. Staff are not confident / competent in pH testing of

i) Acting immediately to remove misplaced tubes on receipt of phone call from Radiology.

j) Supporting their clinical area in developing and sharing knowledge and skills in first line NGT/NJT care.

k) Providing LCAT Assessment for pH testing of Gastric Aspirate gained from NGT

5.8 Radiographers are responsible for;

a) Ensuring the exposure of the x-ray is adequate and should assess if the tube can be seen clearly. They should repeat or seek advice from a Radiologist if appropriate and undertake the following:

- Exposure of the x-ray is adjusted to allow the nasogastric tube to be visible to the bottom of the film.
- The film is centred lower than would normally be appropriate for a chest x-ray so that it shows the abdomen as far as possible below the diaphragm.
- The x-ray film must show the bottom of both hemi-diaphragms in the midline.

b) X-rays that are not taken as described above will not allow accurate interpretation of nasogastric tube placement and should not be made available for viewing on the PACS System.

c) Contacting the qualified ward staff looking after the patient immediately if the tube is identified to be in the lung and request that a competent clinical person removes the tube in Radiology before they are discharged back to the clinical area.

d) Radiographer is responsible for documenting the tube placement checking process includes clear instructions as to required actions and for formally recording these instructions / actions. (NPSA). Medical notes should be requested from the wards and any adverse placement / actions are to be recorded in the patients’ medical notes. In the event the medical notes are unavailable then this should be documented on the CRIS system.

5.9 Dieticians are responsible for;

a) Taking responsibility for nutritional screening, and assessment of the patients feed requirements.

b) Providing the patient with an individual regime of prescribed feed and water flushes. Flushes are not used in the Neonatal Unit.
c) Reviewing the patient and altering the regime as necessary.

d) Completing the registration with Home delivery service for feed and/or equipment.

e) Liaising Community Nursing Team prior to patient discharge.

5.10 **Pharmacists are responsible for;**

a) Ensuring that medications are in correct formulation to be administered safely via the enteral feeding tube. To document instructions for staff/patient/carers on the medication chart or Electronic Prescribing Medicines Administration (ePMA).

5.11 **Student Nurses and trainee nursing associates are responsible for;**

a) Reporting any patient changes or problems with the enteral feeding tube to the Registered Nurse.

b) Administering prescribed feed and water flushes as per the Dietitian’s regime and as per this policy’s instructions under direct supervision of a Registered Nurse.

c) Liaising with the Nurse in Charge in the first instance if there are problems or questions relating to the enteral feeding tube.

d) Following UHL policy when caring for a patient with an enteral feeding tube.

5.12 **Health Care Assistants and Nursery Nurses are responsible for;**

a) HCAs/NN and Nursery Specialist on the Neonatal Unit can provide care and manipulate Enteral feeding if they have completed an appropriate competency training and have documentation that this care has been authorised by their immediate ward Sister / Charge Nurse/Unit Manager.

b) Reporting any patient changes or problems with the enteral feeding tube to the Registered Nurse.

c) Nursery Specialist on the Neonatal Unit can insert NG/OG tubes if they have completed appropriate competency training and have documentation that this care has been authorised by their immediate Ward Sister/Charge Nurse/Unit Manager.

5.13 **Prescribers**

a) Are responsible for the prescription they sign and for their decisions and actions when they supply and administer medicines and devices or authorise or instruct others to do so.

b) Enteral feeds can be prescribed by any professional who is authorised / qualified to do so i.e. Doctor, Dietitian, Non-Medical Prescriber.

5.14 **All UHL Staff**

All UHL staff are responsible for informing relevant managers and clinical leads if there are any implementation or compliance issues with newly developed policies or guidance and for participating in the monitoring of compliance as applicable.
6. Summary

6.1 Note “enteral feeding tubes” is a generic term which includes all tubes accessing the gastrointestinal tract; nasogastric and nasojejunal tubes and are included in this definition.

6.2 When Chest X-ray (CXR) is undertaken to confirm gastric placement the following must be followed;

   a) The Nasogastric Tube (NGT) guidewire must be removed from the NG tube to demonstrate the tip is not curled.

   b) Any patient presenting for CXR with a wire in situ will be sent back to the ward without a CXR being undertaken.

6.3 As advised by the NPSA no elective NGT should be placed in night time hours. This placement time correlates with a greater risk of complications to patients due to reduced staffing numbers on duty overnight.

6.4 Within the UHL Hospitals, enteral / oral purple syringes should be used once and discarded in-line with manufacturer’s guidelines and local policy.

6.5 Patients should never be enterally fed or the tubes flushed or medication administered whilst laid flat - Elevate head of bed by 30-45° degree angle (approximately the height of two pillows).

6.6 NGT that are not placed by anaesthetists under direct vision must have gastric placement confirmed by using Merck pH sticks 0-6.

6.7 No water, fluid, medication or feed is to be introduced to any tube until gastric placement has been confirmed.

6.8 In line with NHS England guidance NGT / Nasojejunal Tube (NJT) placement devices such as electromagnetic tube placement machines do not replace pH testing or CXR as gastric / jejunal placement checks.

6.9 In line with National Patient Safety Agency (NPSA) guidance NGTs used for feeding should be radio-opaque along their entire length, be CE marked and have external visual length markings.

7. EDUCATION AND TRAINING REQUIREMENTS

7.1 It is the responsibility for all UHL staff involved in the insertion and post-insertion care of enteral feeding tubes to update their practice to maintain competence and skills.

7.2 Education or training issues should be highlighted at appraisal and addressed through the personal development plan.

7.3 It is the responsibility for all staff and carers undertaking pH testing for tip placement confirmation of NGT to ensure that they have completed and passed the ward / area
based UHL LCAT pH testing competency assessment. This is a one off assessment required as part of Local induction.

7.4 It is the responsibility for all medical staff reporting tip placement confirmation of NGT after radiological investigation to ensure that they are competent to do so. Trainee Practitioners identifying training needs with regard to tip placement confirmation of NGT in Radiology should flag up needs with their Educational Supervisor, Consultant staff, their appraiser or the Associate Medical Director - Medical Education.

7.5 E-learning to support tip placement confirmation can be found at http://www.trainingngt.co.uk/site/home.aspx It has been endorsed by the NPSA and approved for Distance-Learning Credits for the CPD Scheme of the Federation of Royal Colleges of Physicians of the UK

8. PROCESS FOR MONITORING COMPLIANCE

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>Tool</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If X-Ray used to confirm position – the radiographer must record that the tube can be clearly seen on the x-ray in the child’s notes and clear instructions as to the required actions given</td>
<td>Consultant radiologist</td>
<td>Audit</td>
<td>Annually</td>
<td>Prevalence Survey</td>
</tr>
<tr>
<td>2. An NG sticker is placed in the medical notes on insertion of NGT placement</td>
<td>Matron</td>
<td>Audit</td>
<td>Annually</td>
<td>Prevalence Survey</td>
</tr>
<tr>
<td>3. pH testing is recorded a minimum of daily or 4 hourly(CICU) on Fluid Balance Chart. In neonatal Unit the pH must be recorded as a minimum every 6 hours</td>
<td>Matron</td>
<td>Audit</td>
<td>Annually</td>
<td>Prevalence Survey</td>
</tr>
<tr>
<td>4. An incident form is completed for misplaced tubes and actions taken disseminated through the CMG governance processes</td>
<td>Ward Sister</td>
<td>Audit</td>
<td>As occurs</td>
<td>Ongoing Datix reporting and actioning at ward and CMG level</td>
</tr>
</tbody>
</table>

9. EQUALITY IMPACT ASSESSMENT

9.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

9.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.
10. SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES


National Nurses Nutrition Group 2016. Good Practice guideline - Safe Insertion and Ongoing Care of Nasogastric (NG) Feeding Tubes in Adults. www.nnnng.org.uk


National Patient Safety Agency (NPSA) NPSA/2012/RRR001 Harm from flushing of nasogastric tubes before confirmation of placement. 2012.

National Patient Safety Agency (NPSA) NHS/PSA/RE/2016/006 Nasogastric tube misplacement: continuing risk of death and severe harm


NHS England Nasogastric Tube Insertion Management. Poster by Gemma Peacock and Tori Morley (last accessed 24/10/17)


Insertion and Management of Nasogastric and Nasojejunal Tubes in Adults. B39/2005

11. PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

11.1 Once this Policy has been approved by the UHL P&G Committee, Trust Administration will allocate the appropriate Trust Reference number for version control purposes.

11.2 The updated version of the Policy will then be uploaded and available through Policy and Guidelines Documents and the Trust’s externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts SharePoint system.

11.3 This Policy will be reviewed every three years or sooner in response to clinical risks/ incidents identified.
1. **Introduction**
   To guide the selection of equipment for the safe insertion and placement checking of bedside nasogastric tubes (NGT) / Orogastric (OG)

2. **Scope**
   This applies to all staff undertaking bedside NGT/OG placement in infants and children

3. **Nasogastric Tubes**
   There are two types of nasogastric tubes available. Nasogastric tubes used for the purpose of feeding are radio-opaque throughout their length and have externally visible length markings. These have been chosen to enhance visibility on computerised radiology systems such as those used within UHL.

   In infants and children Ryles NG Tubes must only be used in emergency situation for gastric drainage or aspiration

**Figure 1**

<table>
<thead>
<tr>
<th>Material</th>
<th>Fine Bore</th>
<th>Wide Bore</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polyurethane (PUR) (Not used in Neonates)</td>
<td>Polyvinyl Chloride (PVC)</td>
<td></td>
</tr>
<tr>
<td><strong>Size</strong></td>
<td>• 6Fr (used for standard feeds)</td>
<td>• 6-10 Fr</td>
</tr>
<tr>
<td></td>
<td>• 7Fr (used for higher density and fibre feeds)</td>
<td>• In Neonatal Unit – 4Fr, 5Fr, 6Fr &amp; 8 Fr</td>
</tr>
<tr>
<td></td>
<td>Tubes come in a range of lengths usually 36cm, 56cm, 90cm, 110cm available</td>
<td></td>
</tr>
<tr>
<td><strong>Information</strong></td>
<td>• A long term nasogastric feeding tube is usually made of polyurethane and will often have a guidewire throughout its length, stiffening the tube to aid the insertion process.</td>
<td>• A short-term nasogastric feeding tube is usually made of PVC or low grade polyurethane and may be recommended for use up to 7-10 days.</td>
</tr>
<tr>
<td></td>
<td>• Lifespan of this type of tube is usually 6 to 8 weeks but may vary according to individual manufacturers.</td>
<td>• Refer to manufacturer’s guidance for individual product lifespan.</td>
</tr>
<tr>
<td></td>
<td>• Refer to manufacturers’ guidance and NPSA guidance for product lifespan.</td>
<td>• If a PVC tube is used for feeding it must be NPSA compliant (NPSA 2011)</td>
</tr>
<tr>
<td><strong>Use</strong></td>
<td>• Enteral feeding</td>
<td>• Enteral Feeding, stomach aspiration and drainage</td>
</tr>
<tr>
<td><strong>Advantages</strong></td>
<td>• Soft material</td>
<td>• Easy gastric aspiration</td>
</tr>
<tr>
<td></td>
<td>• Patient usually becomes unaware of tube within a few hours of insertion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patient can eat and drink normally</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Size 7Fr enables rapid gastric aspiration</td>
<td></td>
</tr>
</tbody>
</table>
Disadvantages

- Can be difficult to aspirate
- May cause longitudinal strictures
- May cause ulceration of the oesophagus
- May cause ulceration of the nasal tissue.
- Hard and uncomfortable, may limit patients solid food intake

Ideal time insitu

| 28 days - 6 months(on a named patient basis with documentation from the manufacturer) | Up to 10 days |

Figure 2 – Size Selection for Infants and Child NG/OG Tubes (excluding Babies on Neonatal Unit See figure 3)

<table>
<thead>
<tr>
<th>For Paralytic Ileus, Gastrointestinal Disease, or Gut Surgery</th>
<th>For Ventilated Infants</th>
<th>For Enteral Feeding or Obtaining Gastric Contents for Diagnostic Purposes</th>
<th>For Gastric Lavage or Barium X-Ray</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size 6 as standard but may require a Size 8</td>
<td>Below 1.5kg – <strong>Size 4</strong> Above 1.5kg – <strong>Size 5</strong> Above 5kg – <strong>Size 6</strong></td>
<td>Below 1.5kg – <strong>Size 4</strong> Above 1.5kg – <strong>Size 5</strong> Above 5kg – <strong>Size 6</strong></td>
<td>Appropriate Size for Medium</td>
</tr>
<tr>
<td><strong>An Infant or Child may require a Size 8 Tube to accommodate a thicker feed</strong> You Must Use Professional Judgement these are Guidelines Only</td>
<td></td>
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</tbody>
</table>

Figure 3- Tube Size selection for babies on Neonatal Unit

<table>
<thead>
<tr>
<th>Babies up to 1.8 kg</th>
<th>Size 4 Fr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babies over 1.8 kg</td>
<td>Size 6 Fr</td>
</tr>
<tr>
<td>For ALL surgical babies</td>
<td>Size 8 Fr</td>
</tr>
<tr>
<td><strong>At all times the size of the neonates nares and respiratory support being given must be considered prior to tube selection</strong></td>
<td></td>
</tr>
</tbody>
</table>
1. **Syringes**
   a) **Infants and Children** – 50 ml for all Polyurethane (PUR) tubes - long term tubes (often known as ‘silk tubes’). **20 ml for Polyurethane (PUR) Short Term Tubes** – though 5ml can be used for Neonates and Small Infants.
   b) All enteral feeding systems will consist only of enteral feeding licensed plastics.
   c) All enteral feeding systems used now are EN-FIT, to reduce compatibility with other routes.
   d) **Three-way IV taps must not be connected to any enteral feeding device.**
   e) No syringe or adaptor that can connect to any type of IV plastic in any area of UHL whether ward or department.
   f) Please note, within UHL, all oral / enteral syringes must be used only once.

2. **pH paper**
   a) In line with NPSA Alert NPSA/2011/PSA002 all pH indicator paper must be CE marked and intended by the manufacturer to test human gastric aspirate.
   b) Within UHL, Medicina CE marked pH paper test strips 0-6pH with 0.5 pH increment markers are used.
   c) Each test and test result must be documented on a chart kept at the patient’s bedside (NPSA 2011)
   d) **The NPSA recommend a pH 5.0 or above on first test two qualified staff independently check to confirm the reading. A feed is safe to be administered if the pH is 5.5 or below**

3. **Tube Securing** – The tube should be safely secured to the side of the face by hypoallergenic tape with a hydrocolloid dressing (e.g. duoderm or comfeel extra thin) beneath the tube to aid pressure relief and maintain skin integrity.
   Neonates must use a transparent dressing such as Tegaderm due to issues with fragile skin.

4. **Other Equipment:**
   a) Plastic Aprons, Clean Gloves from a dedicated box, Orange Clinical Waste Bags
   b) Hard Plastic Tray or Trolley
   c) Nutrison Sterile Water labelled with time and date of opening - to flush the tube after aspiration and confirmation of gastric placement. Flushing is not required for babies on the neonatal Unit
   d) Dummy, Feeding Bottle or Drink with a straw *(if appropriate)*
   e) Suction and Resusitation equipment within easy reach
   f) NG tube sticker to put in medical notes following insertion of every tube
1. Introduction / Scope

The procedure is aimed at all Health Professionals involved in the care of Infants and Children within University Hospitals of Leicester.

2. Key Points

Before the decision is made to insert an NGT an assessment is made to establish the reason for inserting the nasogastric tube and document this in the healthcare record. Check that there are no contra-indications to passing a nasogastric tube, such as anatomical deformity, trauma, recent oral, nasal or oesophageal surgery, or severe gastro-oesophageal reflux disease (GORD).

### Procedure for Insertion of a Nasogastric/Orogastric Tube in Infants and Children

<table>
<thead>
<tr>
<th>No</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Depending on the age and development of the child, explain the procedure to them and their parents or carers (person with parental responsibility) and obtain their verbal consent. Where the NG tube is to be used for feeding purposes, parents should be made aware of the associated complications which may be caused by tube misplacement and the measures put in place to prevent this happening.</td>
</tr>
<tr>
<td>2</td>
<td>Minimal handling and an aseptic no-touch technique (ANTT) must be used throughout all NG procedures.</td>
</tr>
</tbody>
</table>
| 3  | Before starting the procedure you must position the infant or child to ensure they are safe & secure  
   - Infants under the age of 1 year should be wrapped securely in a blanket or sheet. For babies on the Neonatal Unit the babies do not to be wrapped however the safety of the babies skin must be considered at all times.  
   - Older children may sit in an upright position on an adult's knee or supported by pillows – if appropriate |
| 4  | If the tube is a replacement tube use the alternative nostril to reduce the risk of mucosal erosion. |
| 5  | Establish the appropriate distance on the NG tube by measuring the distance from the infant/ child’s tip of nose to earlobe to xiphisternum (NEX measurement), mark with tape or make a note of the measurement as this must be recorded in nursing notes following the procedure on the insertion sticker. In Neonates measure from the tip of the patients nose to the ear lobe and then to the midpoint between the sternum and umbilicus (NEMU measurement) |
| 6  | For orogastric tubes start the measurement from the centre of the lips. |
**Procedure for Insertion of a Nasogastric/Orogastric Tube in Infants and Children**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Check that the tube is intact if the tube has a guidewire ensure that it moves freely within the tube that it is not kinked or protruding from the end.</td>
</tr>
<tr>
<td>8</td>
<td>Using a second person to hold the child’s head, gently pass the tube into the child’s nostril advancing it along the floor of the nasopharynx to the oropharynx until the predetermined mark is reached. In Neonatal Unit this procedure can be performed by one person. At this point as the child swallows you may be able to get them to swallow a little water, or suck on the feeding bottle or dummy, but not during orogastric insertion.</td>
</tr>
<tr>
<td>9</td>
<td>If any obstruction/resistance is felt you must withdraw the tube and try again in a slightly different direction or use the other nostril.</td>
</tr>
<tr>
<td>10</td>
<td>If the infant/child shows signs of distress, breathlessness, severe coughing, gasping or cyanosis – you must remove the tube immediately.</td>
</tr>
<tr>
<td>11</td>
<td><strong>YOU MUST NOT USE THE TUBE FOR FEEDING UNTIL THE POSTION HAS BEEN CONFIRMED BY AN AUTHORISED PROFESSIONAL/CARER PRIOR TO USE</strong></td>
</tr>
<tr>
<td>12</td>
<td>Only once the correct position has been confirmed, if a guidewire is used, flush the lumen with sterile water, remove the guidewire if present using gentle traction, (this is not required in neonates). If the tube is for <strong>Single Use</strong> discard the guidewire in the sharps bin If the tube is for <strong>Single Patient Use</strong> retain the guidewire which should be cleaned, dried and placed in a sealed bag, labelled with the child’s name for re-use. (Tube position should be swapped from nostril to nostril every 4-6 weeks)</td>
</tr>
</tbody>
</table>
| 13   | Secure the tube to the cheek with hypoallergenic tape and/or appropriate fixation device. For babies on the Neonatal Unit use tegaderm to secure the tubes.  
  - Ensure skin is clean & dry and free from any creams, oils, mucus or feed to promote adhesion  
  - You must regularly check the security of the tube to help prevent accidental dislodgement  
  - You must observe regularly for any signs of nasal or check trauma. |
| 14   | Record in the child’s notes the size and type of tube that has been used, the length of tube inserted and that the correct placement has been confirmed using the appropriate stickers (appendix 5). You must check the manufacturer’s instructions regarding the length of time the tube can be left in situ |
1. Introduction / Scope

The procedure is aimed at all Health Professionals involved in the care of Infants and Children within University Hospitals of Leicester

<table>
<thead>
<tr>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Correct NG/OG tube position must be confirmed:</td>
</tr>
<tr>
<td></td>
<td>• At the time of insertion</td>
</tr>
<tr>
<td></td>
<td>• Before each use</td>
</tr>
<tr>
<td></td>
<td>• In the event of the child/infant having an episode of Retching, Vomiting, Excessive Coughing, Respiratory Distress</td>
</tr>
<tr>
<td></td>
<td>• Following a successful attempt to resolve a blocked tube</td>
</tr>
<tr>
<td></td>
<td>• In the event that the tube appears to have partially dislodged i.e. – when the visible tube length has increased/decreased.</td>
</tr>
<tr>
<td></td>
<td>• At least once a day during continuous pump delivered feeds</td>
</tr>
<tr>
<td></td>
<td>• For babies on the neonatal Unit the pH must be checked as a minimum every 6 hours</td>
</tr>
<tr>
<td>2</td>
<td>If this is not following tube insertion, gently insert 1-6ml of air to free feeding ports from mucosa and debris, water or feed</td>
</tr>
<tr>
<td></td>
<td>• 4-5 FG Tubes – 1ml of air</td>
</tr>
<tr>
<td></td>
<td>• 6-8 FG Tubes – 5ml of air</td>
</tr>
<tr>
<td></td>
<td>• Ryles Tubes – 6ml of air (sometimes used post-op in PICU or ED for drainage or aspiration but MUST not be used for feeding purposes)</td>
</tr>
<tr>
<td></td>
<td><strong>AUSCULTATION OR THE WHOOSH TEST IS NOT A RELIABLE METHOD OF CONFIRMING TUBE POSITION &amp; MUST NOT BE USED</strong></td>
</tr>
<tr>
<td>3</td>
<td>• If the <strong>pH 5.0 or below</strong> indicates Correct Tube Placement and feed may be given if required – where a minimal quantity of feed is given, aspirate may be administered to maintain nutritional needs</td>
</tr>
<tr>
<td></td>
<td>• The <strong>pH is 6.0 or above</strong> indicates STOP the tube may be in the intestine or oesophagus you must try:</td>
</tr>
<tr>
<td></td>
<td>• Check the external tube length is the same as previously documented if there are obvious signs of tube displacement reposition and re-aspirate</td>
</tr>
</tbody>
</table>
|    | • To increase gastric secretion, encourage sucking on dummy, gently change
position of infant/child or encourage activity and retry- if appropriate wait 15 minutes before reaspirating

- It is important to be aware that some medications such as proton pump inhibitors and H2 receptor blocking agents can elevate gastric pH readings. Omeprazole or Ranitidine may also affect the pH it may therefore take an hour post medication for gastric pH to raise. Domperidone will speed up the process of gastric emptying.

- Offer acid based drink or fluid containing food colouring, if appropriate and reaspirate.

- If the pH remains 6.0 or above you must use the Decision Tree (pg 4) & Risk Assessment and discuss with the Multidisciplinary Team

4 If you are unable to obtain a gastric aspirate try:

- On initial insertion, gently advance or retract tube and reaspirate at 1cm intervals

- For subsequent testing check for signs of tube displacement and reposition as necessary and document changes
  - To reposition the infant/child onto their left side
  - Inject 1-6 ml of air into the tube using a syringe (see Section 2)
  - If appropriate gently change infant/child’s position or encourage activity or movement
  - Give mouth care to patients who are nil-by-mouth
  - Offer infant a dummy and encourage sucking
  - If appropriate offer infant/child oral fluid
  - If appropriate wait for a further 15 minutes and retry aspirating

5 If you are still unable to obtain aspirate:

- Consider that the tube may be blocked or misplaced
- Discuss with more experienced staff
- Consider removing and replace the tube unless contra-indicated (e.g. after oesophageal/gastric surgery in which case contact senior member of the surgical team)
- If the patient has a Transanastomotic tube the tube MUST NOT be removed by the ward team. All concerns should be discussed with the paediatric surgeon.

6 Tube position confirmation by X-Ray:

- To minimise the exposure of children/infants to radiation an X-ray must be used only as a second line test after trying all of the options as above in section 4 and 5
- The x-ray form must clearly indicate that the purpose of the x-ray is to confirm the tube position for feeding.
- The x-ray is only accurate at the time it is taken and cannot be used for ongoing confirmation.
• Remove wire from NG tube - any proposed CXR on a tube with a guidewire in situ will be refused. The guidewire needs to be removed to demonstrate the tip is not curled.

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

• The competent clinician (Radiographer) must take responsibility to ensure the tube can be clearly seen on the x-ray. Documentation of the tube placement checking process includes confirmation that any x-ray viewed is the most current x-ray for the correct patient, how the placement was interpreted, and clear instructions as to required actions.

• It should be noted that the CXR will not be reviewed by a radiologist for >1 week therefore the medical team are responsible for checking and documenting the CXR once it is available.

7 Department based CXR - In the event the tube appears misplaced, the child must be accompanied by a registered practitioner to allow the immediate removal of the tube if necessary;
1. If the tube needs adjusting but not immediate removal, secure the nasogastric feeding tube before it leaves the radiology department to show it is not in the correct place and cannot be used for feeding.

8 Ward based CXR - In the event the tube appears misplaced on initial radiographer review it is the responsibility of the radiographer;
1. Inform the nurse looking after the patient of the misplaced tube and explain it is not in the correct place and cannot be used for feeding.
1. Introduction

To guide the selection of equipment for the safe insertion and placement checking of bedside nasogastric tubes (NGT) / Nasojejunal tubes (NJT)

### Procedure for Ongoing Care of Nasogastric/Orogastric Tube in Infants and Children

<table>
<thead>
<tr>
<th>No</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Tube Flushing</strong></td>
</tr>
<tr>
<td></td>
<td>- For babies on the Neonatal Unit NG/OG tubes are not flushed at all.</td>
</tr>
<tr>
<td></td>
<td>- If the tube is not flushed appropriately, it will become blocked and require replacing</td>
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<tr>
<td></td>
<td>- The tube must be flushed with sterile water—see the child's/infants individual feeding plan and refer to the manufacturers guideline on suitable amounts.</td>
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<tr>
<td></td>
<td>- In most infants and children the tube must be flushed before and after administering feeds, before, after and between medications. However in Neonates tubes are not flushed.</td>
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<tr>
<td></td>
<td>- To maintain patency the tube must be flushed at least 6 hourly if not in use – unless the child is fluid restricted</td>
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<tr>
<td></td>
<td>- If it is not possible to flush the tube due to a blockage you must consider replacing it, attempting to flush a blocked tube may result in tube rupture with damage to the surrounding structures or aspiration of fluid if excessive force is used.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Patient Monitoring:</strong></td>
</tr>
<tr>
<td></td>
<td>Respiratory Status – Observe for changes in the usual respiratory pattern indicating respiratory distress</td>
</tr>
<tr>
<td></td>
<td>- Increase/Decrease of respiratory rate</td>
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<tr>
<td></td>
<td>- Coughing or increased mucus production</td>
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<tr>
<td></td>
<td>- Pyrexia or Tachycardia – which may indicate chest infection</td>
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<tr>
<td></td>
<td>- Skin pallor/cyanosis</td>
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<tr>
<td></td>
<td>- Oxygen Satuations level if being monitored</td>
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<td></td>
<td>- Change in conscious level, response or behaviour</td>
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<tr>
<td></td>
<td>- Feeds must be stopped immediately with any coughing, gagging or vomiting or signs of respiratory distress and must not be commenced until the tube position is confirmed</td>
</tr>
<tr>
<td><strong>Procedure for Ongoing Care of Nasogastric/Orogastric Tube in Infants and Children</strong></td>
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</tr>
<tr>
<td><strong>Tube Trauma</strong> –</td>
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<tr>
<td>• Bleeding, soreness or ulcers visible in the nasal cavity, on the nares or on the cheek</td>
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<tr>
<td>• Coughing or vomiting blood stained fluid, increase in swallowing action especially if the child is in a recumbent position and which may indicate post-nasal trauma</td>
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<tr>
<td>• Skin integrity compromised by adhesive or tube pressure</td>
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<tr>
<td><strong>Fluid &amp; Nutritional</strong> –</td>
<td></td>
</tr>
<tr>
<td>• Before commencing NG feeds a PYMS Nutritional Assessment must be completed and re-assessed weekly. For babies on the Neonatal Unit the nutritional status is assessed as a minimum daily.</td>
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</tr>
<tr>
<td>• All enteral, oral intake, vomit, urine, bowel movements and NG aspirate should be recorded on the Fluid Balance Chart. On the neonatal Unit all feeds are recorded on the ITU chart of the feed chart.</td>
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</tr>
<tr>
<td>• Check tube for signs of leakage or tears from feeding ports or the tube to prevent loss of gastric or nutritional fluid</td>
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</tr>
<tr>
<td>• All infants and children receiving enteral nutrition must be weighed twice weekly unless otherwise directed</td>
<td></td>
</tr>
<tr>
<td><strong>Feeding</strong> –</td>
<td></td>
</tr>
<tr>
<td>• Unless contra-indicated children should be fed at an angle of 30-45 degrees to aid digestion not prone as this can increase the risk of aspiration. Babies on the neonatal Unit can be nursed prone when receiving feeds via NG/OG tube if they are on continuous monitoring.</td>
<td></td>
</tr>
<tr>
<td>• If milk feed or enteral feed is not the usual source of nutrition the child must be referred to the Dietician for assessment and a feeding plan, which is agreed with the medical staff, prior to commencing feeds.</td>
<td></td>
</tr>
<tr>
<td>• All infants and children receiving NG/OG feeds must have a daily feeding plan with consideration to their fluid and nutritional requirements</td>
<td></td>
</tr>
<tr>
<td>• Minimal Handling and an aseptic no-touch technique (ANTT) must be used to connect the administration set to the enteral feeding tube.</td>
<td></td>
</tr>
<tr>
<td>• NG/OG feeds may be administered intermittently as a bolus or via a rate controlled feeding pump or as a slow rate continuous feed which is given up-to 20 hours per day with a rest period before commencing the next feed (bolus feeds are only appropriate for NG/OG rather than NJ tubes)</td>
<td></td>
</tr>
<tr>
<td>• Pre-packaged feeds from a manufacturer once opened can be hung for a maximum of 24 hours, admin sets must be changed every 24 hours. Feeds decanted into a bottle or container can be hung for 4 hours only. As some feeds, which have a low acid pH of 2.8-4.0, feeds flavoured with SHS and Expressed Breast Milk the NG/OG tube must be clear before aspirating gastric fluid.</td>
<td></td>
</tr>
<tr>
<td>• Feeds made by the milk kitchen and can only be kept in the fridge for 24hrs</td>
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</tbody>
</table>
Procedure for Ongoing Care of Nasogastric/Orogastric Tube in Infants and Children

and then need to be thrown away.

- Formula milk is now made up for each feed if it is powder and if ‘ready-made’ best to follow the manufacturer’s guidelines on storage, which would normally be 24 hours.

- Expressed breast milk when stored in hospital surroundings-
  
  **Freezer** – 3 Months
  
  **Refrigerator** at 2-4°C – 48 hours
  
  **Room Temperature** 19-23 degrees - 6 hours

  Thawed Milk can be refrigerated for up to 24 hours

Gastrointestinal Disturbance –

- Nausea and Vomiting may be related to:

- Bacterial Contamination

- Delivery too fast/ volume of feed

- Poor gastric emptying

- Excessive air in stomach

- Constipation or related to disease/treatment

- Diarrhoea may be related to:

- Migration of the tube to the small bowel

- Infection

- Medication such as antibiotics

- Chemotherapy

- Laxatives

- Constipation may be related to:

- Low fluid intake

- Low fibre intake

- Poor gut motility

- Medication such as analgesics, antispasmodics, iron supplements and some anticonvulsants

3 Oral Hygiene:

It is essential to maintain regular oral hygiene in children and infants who are not orally fed. For babies on the Neonatal Unit this must be carried out every 6 hours as a minimum.

It is essential to encourage infants and children to take oral diet if they are able, the use of a dummy for infants and to encourage older children to use their mouth in play.
### Procedure for Ongoing Care of Nasogastric/Orogastric Tube in Infants and Children

Activities can help maintain or develop their normal sucking/feeding responses. Inclusion in family meal times and feeding at the meal table can also help to improve socialisation.

### Administration of Medicines via an NG Tube:

To minimise the risk of complications associated with the administration of medications via a Nasogastric tube, please note that it is imperative that the correct route of administration is determined before administration.

A Medication must only be administered via a Nasogastric tube if it has been prescribed (route NG) by a Registered Practitioner.

- The person administering the drug must check the Six Rights (right patient, right drug, right dose, right route, right time & right Documentation?)
- The person administering the drug must carefully check that the right tube is identified prior to the administration of medication.
- The drug must be administered to the patient using an enteral syringe.
- If there is any concern about the absorption of medications administered via the Nasogastric tube you MUST consult the Pharmacy Department.
- If the person administering the drug is in any doubt about any of the above, they should not proceed with the administration of the Medication.
- All medication administered via this route must be prescribed as such on the prescription chart
- Where possible medication given via NG/OG tube should be dispensed as a liquid/solution medication
- If medication not in liquid form, check solubility with pharmacist – certain medications should not be crushed, eg enteric coated, modified & slow release tablets or cytotoxic preparations. Check with pharmacist if medicines can be mixed together.
- Large particles or insoluble preparations may block the tube, resulting in the need for tube replacement

### Discharge of an Infant or Child with an NG Tube

- A full multidisciplinary supported risk assessment is made and documented before a patient with a Nasogastric tube is discharged from acute care into the community.
- A working feeding plan must be formulated in conjunction with the Dietician, Parents/Carers with regards to the Infant or Child’s nutritional needs and lifestyle.
- Parents/Carers must undertake training, supervised practice and competency assessment on all aspects of the procedure and care of their child and the NG tube – this must be documented in the Children’s Services Parents NG competency assessment booklet & Case Notes.
- Parents/Carers must be made aware of whom to contact for emergency.
### Procedure for Ongoing Care of Nasogastric/Orogastric Tube in Infants and Children

<table>
<thead>
<tr>
<th>advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Within Leicestershire - Referral must be made to the Home Enteral Nutrition Service (Tel: 0116 272 7216) and the Children’s Community Nursing Service (Tel: 0116 2255453) at least 5 days warning must be given</td>
</tr>
<tr>
<td>• In Neonates the Neonatal outreach team must be involved in the discharge and follow up process for all babies going home with NG/OG tubes.</td>
</tr>
<tr>
<td>• If an enteral feeding pump is required, provision of this will be arranged by the Home Enteral Nutrition Service for children transferred to the Leicestershire HENS</td>
</tr>
<tr>
<td>• Outside of Leicestershire – Referral must be made to the Paediatric Dietician to refer to Dietician service in Child’s own area</td>
</tr>
<tr>
<td>• You must consider who else needs to be involved in the Child’s care (with NG Feeds) – ie Nursery, School Nurse, Respite Care, HV, GP.</td>
</tr>
<tr>
<td>• Ensure equipment and Medication is ready for the discharge</td>
</tr>
<tr>
<td>• TTO’s should include a week’s supply of enteral feed and equipment</td>
</tr>
</tbody>
</table>
Appendix 5.

Infant and Child Patients – Sticker to Document NG/OG Tube Insertion

<table>
<thead>
<tr>
<th>INSERTION OF A NASOGASTRIC TUBE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHILD AND INFANT PATIENTS</td>
</tr>
</tbody>
</table>

**MANUFACTURER OF NG**

**TYPE OF NG TUBE**

**BATCH NO**...**DATE INSERTED**

**EXTERNAL LENGTH OF**

**PROPOSED DATE FOR TUBE REPLACEMENT**

**INSERTED BY:**

**VERIFICATION OF NASOGASTRIC TIP PLACEMENT BY PH PAPER.**

**PH RESULT [PLEASE STATE LEVEL]**

**CHECKED BY: SIGNATURE**

**PRINT NAME**

**TIME**...**DATE**

**THIS MUST BE COMPLETED & ATTACHED WITHIN THE NURSING/CASE NOTES**