Scope
This guideline is aimed at all Health care professionals involved in the care of infants within the Neonatal Service.

Legal Liability (standard UHL statement)
Guidelines issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from any relevant Trust guidelines providing always that such a departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible health professional, it is fully appropriate and justifiable – such decision to be fully recorded in the patient’s notes.

Key Points
- This guideline gives directives for the safe and effective placement of an orogastric tube.
- Effective respiratory management is facilitated by use of an orogastric tube in preterm infants who weigh less than 2 kilograms\(^1\) (Grade B)
- All neonates who are not on CPAP are to continue to have nasogastric tubes unless otherwise indicated.
- Movement of the orogastric tube over the infants tongue may cause vagal stimulation prompting an increasing incidence of apnoea and bradycardia\(^2\) (Grade B).
- Accurate documentation is essential for the safe continuing care of infants with an orogastric tube.
- **The position of the tube must not to be confirmed by auscultation.**
- **All staff need to complete neonatal oro/naso gastric insertion competency.**

Evidence Criteria

<table>
<thead>
<tr>
<th>Evidence according to RCPCH</th>
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<tbody>
<tr>
<td><strong>Grade A</strong></td>
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<td><strong>Grade B</strong></td>
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<td><strong>Grade C</strong></td>
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Aim
This policy aims to support staff in the ongoing management of orogastric tubes in line with UHL policy for insertion and post insertion management of a nasogastric tube in adults, children and neonates.
Background
Infants are primarily nasal breathers and feeding tubes placed down the nasal route can cause partial nasal occlusion, increased work of breathing, increased pulmonary resistance and increased incidence of apnoea or periodic breathing.\(^1\) Nasal resistance accounts for \(\approx 40\%\) of total airway resistance in neonates\(^3\) (Grade C).

Indications for Orogastric Tubes
- Neonates weighing <2kg and receiving nasal or mask CPAP
- Choanal atresia

Process / Procedure
- It is the responsibility of all staff involved in the insertion and post insertion care of orogastric tubes to ensure they are competent to do so
- It is the responsibility for all staff and carers involved in the insertion and post insertion care of orogastric tubes to update their practice to maintain competence and skills
- Assemble equipment:
  - Tray
  - Gloves / apron
  - Enteral tube of the appropriate size
  - Fixing tape e.g. Tegaderm
  - pH paper
  - 5ml enteral syringe
  - Ensure emergency equipment is available and functional
- If possible use a second person to assist with holding and placating the infant
- Wrap the infant gently, but securely
- Follow infection prevention procedure
- To ascertain the correct length
  - Measure from centre of lips to earlobe to midpoint from xiphisternum and umbilicus\(^4\) (Grade c)
  - Note length
- Insert the tube over the centre of the infant’s tongue, sliding backwards and inwards along the surface of the tongue to the oropharynx\(^4\)
  - If any obstruction is felt withdraw slightly and try again from a different direction
- Advance the tube gently through the pharynx
- If the infant shows any signs of distress e.g. gasping, coughing or cyanosis remove the tube immediately
- Check the position of the tube to confirm that it is in the stomach by aspiration, using a 5ml enteral syringe
- Check the aspirate with pH paper for an acidic reaction of 5 or below\(^5\) (Grade C)
- If it is not possible to obtain aspirate try the following
  - Check that the tube is not coiled in the back of the mouth
  - Check that the tube is at the correct measurement
- Turn the neonate onto their left side and retry aspiration
- Alter the position of the tube by advancing or withdrawing very slightly and re-aspirate
- If aspirate is still not obtained or the pH is 6 or above seek experienced advice

**The position of the tube must not be confirmed by auscultation**

- Secure the tube centrally with tegaderm or an appropriate fixation device
- Document date and time of insertion, length and pH at insertion in notes and on daily management charts

**Audit standards**

1. Length of tube and pH at insertion will be noted on the daily management charts (100%)
2. Babies on CPAP who weigh < 2kg will have an orogastric tube in place (80%)

**References**


**Guideline development**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>Feb 2001</td>
<td>Original guideline</td>
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<tr>
<td>July 2011</td>
<td>Neonatal Guidelines Group</td>
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<tr>
<td>Sept 2015</td>
<td>Reviewed by Marie Hoy (Unit Manager)/ Alison Nield (Matron)</td>
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<tr>
<td>Oct 2015</td>
<td>Neonatal Guidelines Group</td>
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<tr>
<td>Oct 2015</td>
<td>Neonatal Governance Group</td>
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<tr>
<td>August 2018</td>
<td>Reviewed by Nicola Owen (Deputy Sister)</td>
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<tr>
<td>August 2018</td>
<td>Neonatal Guidelines and Governance Meetings</td>
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NB: Paper copies of guidelines may not be the most recent version. The definitive guideline is held on SharePoint and the BadgerNet library.