Worcestershire Acute Hospitals NHS Trust

Nasogastric Feeding Tube Insertion and Care Guidelines- Adult

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

INTRODUCTION

This guideline provides evidence based guidance for all health care professionals on how to insert, check placement of and care for a fine bore nasogastric feeding tube in adults.

Patients covered are those adults who require feeding/hydration via the nasogastric route on whom it is safe to pass a nasogastric tube.

THIS GUIDELINE IS FOR USE BY THE FOLLOWING STAFF GROUPS :
Registered nurses, doctors, dietitians and speech and language therapists.

Lead Clinician

Dr Thea Haldane	Consultant Gastroenterologist
Morag Ingles	Lead for SLT and dietetics
Jon Howard	Professional development
Sarah Pritchard	Senior Dietitian

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Noted by Medicines Safety Committee:	9th March 2022
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Key amendments to this guideline

Date	Amendment	By
August 2010	• Competencies Infinity pump • Details of syringe • Reference for confirming NG tube position • Document pH obtained • Attempt to obtain aspirate • Infinity pump replaces Flocare pump • Out of hours enteral regimen in Nutrition resource Folder on wards • Clarification water used needs to be sterile • Infection control measure for sterile water • Updated discharge plan • References and bibliography updated	Sue Dickinson
7th September 2012	• Remind all staff responsible for checking initial placement of nasogastric tubes (including staff who support parents/carers who check initial placement of nasogastric tubes). • **NOTHING** should be introduced down the tube before gastric placement has been confirmed. • **DO NOT FLUSH** the tube before gastric placement has been confirmed. • Internal guidewires/ stylets **should NOT** be lubricated before gastric placement has been confirmed. The lubricant is not needed for placement, only to aid removal of the guidewire/ stylet from the tube after gastric placement has been confirmed.	Rani Virk
9th October 2012	• NG Position record appendix 2 and references to it • Discharging a patient on an NG tube feed Appendix 3 and references to it	Sue Dickinson
19th July 2013	Remove Senior Healthcare Assistants from page 1	Helen Blanchard
April 2015	• Policy Review • Inclusion of updates form Marsden Manual • Inclusion of Appendix 2 Insertion record WR4548 • Inclusion of Appendix 3 Maintenance Record • Inclusion of Flow chart from radiology following request for x-ray to determine placement of nasogastric feeding tube.	Joanna Logan
January 2016	• Updated monitoring tool • Addition of link to consent policy • Addition of link to Training	Joanna Logan
August 2017	• Flow chart removed from page 10 of the document as procedure stated is not followed	Julia Rhodes

05th Dec 2017	• Sentence added in at the request of the Coroner	
December 2017	• Document extended for 3 months as per TLG recommendation	TLG
May 2018	• Updated competencies, inclusion of Speech and Language Therapists, removal of Dietitians for competencies to pass tubes • Updated insertion procedure • Inclusions of recommendations from NPSA and local Never Events and NHSi Resource set • Updated sections on confirming placement • Included references to appropriate guidelines, resource information on the intranet including Feeding considerations pathways and links. • Organisation into sections • Updated pH to 5.5 in line with National guidance. • Updated troubleshooting • Updated audit • Inclusion of discharge on NG information and resources in appendices • Inclusion of discharge checklist	Sue Dickinson
August 2018	• Feeding position poster Appendix 4 updated and to be available from Xerox • Chest X-ray requests are electronic	Sue Dickinson
January 2019	• NG Tube Insertion Record and Safety standards sticker • Enteral Feeding Poster updated	Sue Dickinson/Jonathon Howard
April 2020	Amendment made to last box in Appendix 8 to make it clearer to all Dietitians what was required on discharge	Katherine Mckenna
August 2020	Document extended for 6 months whilst document is reviewed and updated	Sarah Pritchard
February 2021	Document extended as per Trust agreement 11.02.2021	
August 2021	Document extended for 3months whilst document is reviewed and updated	Jingjing Ruan
November 2021	Document extended for 6 months as no nutrition nurse in post	Thea Haldane
February 2022	Document extensively reviewed, updated and training clarified	Thea Haldane

Nasogastric Feeding Tube Insertion and Care-Adult

Contents:

INTRODUCTION

Malnutrition is both a cause and a consequence of ill-health. The Trust's adopted Malnutrition Universal Screening Tool (MUST) is about identifying individuals at risk of being malnourished, providing guidance with the correct steps to support good nutritional care and to prevent inappropriate weight loss and dehydration in NHS provided care. A BAPEN 2015 report highlighted an estimated 30% of adults' admitted to hospital and 5% of the total adult populations in England are malnourished.

The consequences of malnutrition include vulnerability to infection, delayed wound healing, impaired function of heart and lungs, decreased muscle strength and depression. Surgical patients, who have malnutrition, have around three times as many postoperative complications and four times greater risk of death than well-nourished patients having similar operations.

All patients who have unsafe or inadequate oral intake should be considered for an alternative route for feeding (Enteral Feeding). There are various routes for enteral feeding depending if it is needed for short or long term use. Methods of short term enteral feeding include Nasogastric (NG), or post pyloric feeding including Nasoduodenal or Nasojejunal (NJ) tube feeding.

Naso-gastric feeding is usually considered as the first line in artificial nutrition support for patients with a functioning gastrointestinal tract whose nutritional needs cannot be met by diet alone or by diet and nutritional supplements. Each patient should be considered individually taking into account the clinical condition, treatment plan and nutritional status. Naso-gastric feeding may be the patient's sole source of nutrition or may be used to supplement the patient's oral diet or as a weaning off parenteral nutrition. People with acute stroke who are unable to take adequate nutrition and fluids orally should receive naso-gastric feeding within 24 hours of admission. (NICE stroke CG162)

If the nasogastric route is used for enteral feeding a fine bore tube should be used. The nasogastric route is suitable for the provision of enteral feeding for up to 4-6 weeks. NICE guidance recommends consideration of gastrostomy feeding if artificial nutrition is likely to be needed for more than 4-6 weeks In this situation a patient should be referred to the nutrition MDT for discussion. For more information regarding the referral process, see: http://nww.worcsacute.nhs.uk/departments-a-to-z/nutrition-mdt/ And refer to PEG guidelines (WAHT-NUT-004).

Nasogastric feeding tubes must be placed in hours when there is sufficient senior support and cover to review pH and X-ray. Insertion of a nasogastric tube should only be inserted out of hours in an emergency.

PATIENTS COVERED

Any patient requiring feeding via the naso-gastric route in whom it is safe to pass a nasogastric tube.

COMPETENCIES REQUIRED

Insertion of naso-gastric feeding tubes may be carried out by a Registered nurse, band 4 health care support worker, Doctor or Allied health professional who has gained the Trust competencies to perform NG tube insertion.

Student nurses and doctors may insert naso-gastric feeding tubes but only under the direct supervision of a registered nurse or doctor who is already competent in the skill having completed the training required by the Trust to gain competencies.

Training sessions on insertion of naso-gastric feeding tubes are available as part of in-service training. Nasogastric tube insertion theory training is provided by the Professional Development team. The course dates can be found on the Trust Intranet page under Education and Training/, Nasogastric Tube Training.

Once training has been completed, the practitioner should carry out three successful supervised insertions under direct supervision from a practitioner who is already competent (has attained these competencies) before they are deemed competent. Records of competency should be kept by the staff member, the ward and a copy should be sent to learning and development to be stored in the staff member's personal file and updated on ESR.

All healthcare professionals involved with nasogastric tube position checks must be deemed competent via both theoretical and practical assessment.

Care of the naso-gastric feeding tube, may be carried out by a registered nurse provided they have completed appropriate training and been deemed competent to provide the care.

Use of the Flocare Infinity feed pump requires competency based training for the nurse and the patient/carer if the patient is discharged on nasogastric feeding

SECTION 1 ASSESSMENT

Nasogastric feeding is used as a short or medium term method of artificial feeding for patients

- **who have conditions that mean they are unable to take enough food and drink by mouth to meet their nutritional needs**
- **who have conditions such as Stroke where dysphagia leaves them at risk of not being able to swallow food and drink safely**
- **in Critical care or unconsciousness meaning they are unable to swallow at all.**
- It is important to assess capacity.
- Where a patient has capacity, the usual consent process should be followed and verbal consent gained.
- If a patient lacks capacity, a MCA assessment will need to be completed and a best interests process should be followed.
- NB. In the case of a patient who has suffered a stroke and has impaired communication skills, the multi-disciplinary team, in particular, the speech and language therapist, need to be involved in assessing the patient and

determining the patient's level of understanding and capacity to make an informed decision. Information may need to be provided in verbal and pictorial form.

Reason for NG placement

- **It is essential that the reason and rational for NG placement and its purpose is clearly documented in the medical notes** e.g. medication only or for feeding, fluids and medications.
- The expected time/date for nasogastric tube insertion and time frame of duration of use should be specified.
- NG tubes are not generally for long term use, and therefore an ongoing plan for nutrition may need to be considered. The nutrition team and nutrition MDT will advise regarding this.
- Consider whether NG feeding is appropriate. For guidance with this refer to Feeding management considerations under treatment pathways on the intranet.

Contraindications to nasogastric tube placement:

These include:

- Head injury – nasal intubation may be contraindicated in patients with a fractured base of skull because of the risk of intra-cranial insertion.
- Nasal septum injury or Nasal tumors.
- Head and neck surgery
- Oesophageal varices

Situations where it may be difficult to place an NG and endoscopic or ENT guidance may be required include:

- The oesophageal tract is abnormal for example, due to stricture, neoplasm, varices, trauma or postoperatively following a recent anastomosis.
- Gastric outflow obstruction

Situations where it may not be appropriate to consider artificial nutrition include:

- Patients at the end stage of their illness or life. However provision of artificial nutrition may be given to manage symptoms, not to prolong life*
- Dementia – there is no evidence to suggest improved morbidity, mortality or quality of life with gastrostomy feeding in patients with dementia therefore NG feeding should be carefully considered*

Informed Consent

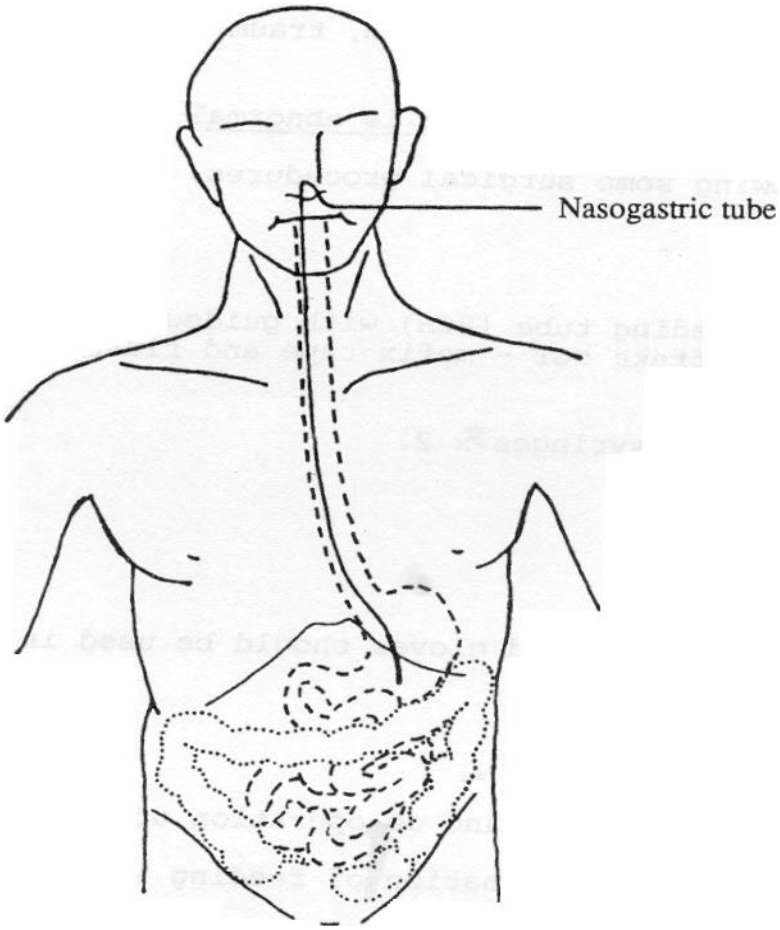
- Capacity should be assessed and documented using the trust MCA documentation before the NG insertion is expected to occur to allow timely feeding decision. The Consent to treatment Policy WHAT CG 075 should be followed.
- Where a patient is known to have communication difficulties, ensure that speech and language therapist advice is followed to optimise communication.
- Obtain the patient's consent before going ahead with the procedure.

- Where the patient is unable to consent or where there are concerns regarding consent then:
- The nurse should aim to reduce the patients' anxieties and allay his or her fears before carrying out the procedure
- Explain fully and clearly in terms the patient will understand the reasons for naso-gastric tube placement
- Invite and encourage questions from the patient
- Dietitians can offer written information on enteral tube feeding Patients and carers can access information at www.pinnt.com
- Where the patient is unable to consent or where there are concerns regarding consent then the **Consent to Examination or Treatment Policy - WAHT-CG-075** should be referred to.

SECTION 2 INSERTION OF NG TUBE AND PLACEMENT CHECKS.

Nasogastric tubes should only be placed when senior support for placement and placement confirmation is available. The tube must not be lubricated prior to insertion as it can alter pH and block holes at the tip of the NG tube.

Procedure for placement of a fine bore naso-gastric feeding tube (Royal Marsden 2015)



Precautionary measures when undertaking the procedure

Seek Medical advice in the following instances:

- Previous attempt at nasogastric tube insertion was difficult
- Recent surgery to face, head or neck
- Poor gastric emptying
- Oesophageal reflux
- Presence of endotracheal tube
- Neurological problems causing an increased risk of aspiration

Aims of carrying out this procedure

- To provide adequate nutrition
- To maintain patient safety
- To ensure comfort and co-operation of the patient

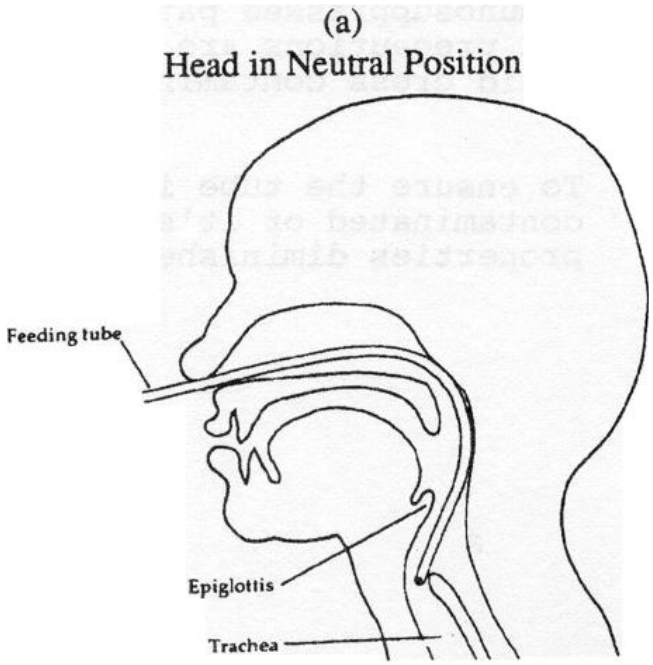
- To monitor patients for complications of naso-gastric feeding
- To administer feed as prescribed by the Dietitian

Equipment needed

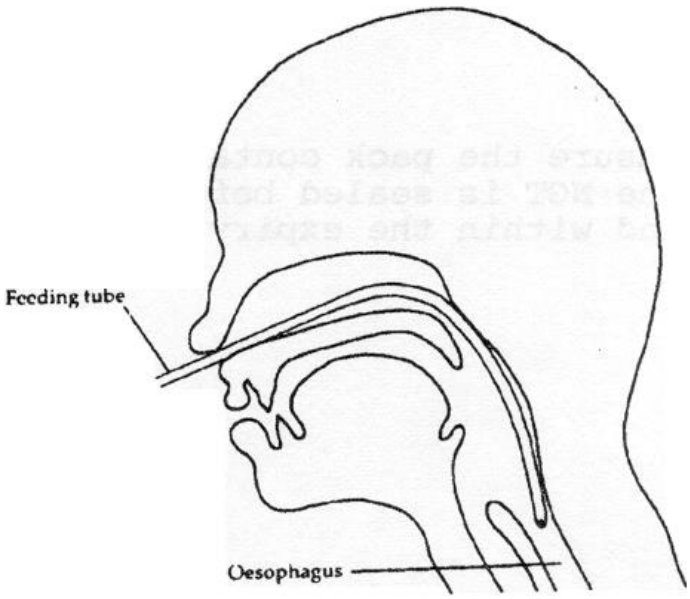
- EnteralUK Nutricare polyurethane naso-gastric feeding tube with ENFit iso 80369-3 connector and guide wire (90days use) fully radiopaque.
- Available in sizes 6FR 50cm and 80cm(NB may not be suitable for a fibre feed) 8FR 50, 80am,92cm 120cm (8FR 92cm Recommended)
- 10FR 92cm
- 12FR 92cm (NB large tube: would a smaller size be more appropriate and comfortable for your patient?)
- pH indicator paper Ce marked for use with human gastric aspirate
- Non-sterile gloves
- 50ml purple enteral syringe (NPSA 2011)
- Sterile water and gallipot
- Clinically clean receiver
- Tissues
- Drinking water and straw (unless contra-indicated)
- Fixative tape
- Enteral feeding sticker for medical notes to document placement and initial placement checks (use **NG Tube Insertion Record Label** ordered from Xerox: 2 stickers per page currently a non-stock item but will be added to web store Appendix 2)
- If using an 8Fr Nasogastric bridle, use an 8FR nasogastric tube.
- **NG insertion and manintenance paperwork should be commenced**

N.B. Sterile gloves should be used with immuno-compromised patients.

Position of Head



b) Head flexed slightly forward



CORRECT POSITION FOR PASSING NASO-GASTRIC TUBE

PROCEDURE GUIDELINES

Passing the Naso-gastric feeding tube

1. Ensure verbal consent is gained, the patient understands the procedure and is happy to procedure.
2. Sit patient in a semi-upright position in the bed or chair. Support head with a pillow
3. Agree with the patient a signal by which he or she can indicate to stop the procedure e.g. by raising a hand
4. Measure the length of tube needed to be inserted. Place the tip of the tube against the xiphisternum, measure to the ear lobe and then to the tip of the nose. Note the closest measurement on the tube. When the tape meets the nose the correct length has been inserted.
5. Advance the tube into the nostril, aim the tube horizontally and posteriorly along the floor of the nasal cavity. If obstruction is felt withdraw the tube and try again at a slightly different angle
6. As the tube approaches the naso-pharynx ask the patient to swallow water (unless contraindicated) and advance the tube as the patient swallows. N.B. If the patient starts coughing or gagging when the tube reaches the oropharynx, stop advancing the tube until the coughing stops, then continue
7. If the patient becomes short of breath, cyanosed or experiences chest pain, withdraw the NG tube and seek medical help.
8. When the selected measurement on the tube is reached stop advancing the tube.
9. Lightly tape the tube to the cheek
10. Confirm position of tube
    (see page 13)
11. Remove guidewire

PLACE STICKER IN PATIENTS NOTES AND DOCUMENT PLACEMENT CLEARLY (See appendix – 2)

Confirming Tube Position

Establishing the correct position of the tube in the stomach is essential to the safety of the patient, as intrapulmonary feeding or aspiration owing to a poorly positioned tube may have serious consequences including aspiration and death.

The tube position must be confirmed before anything can be introduced down the tube. There are two methods available for confirming tube position **Aspiration** and where this fails **X-ray**.

Aspiration

Aspirate stomach contents from the tube and test aspirate with pH indicator paper, a **pH of equivalent to or <=5.5 indicates gastric acid and correct positioning of the tube** (Second nurse to check pH obtained)

If no aspirate can be obtained: try again; change the patients' position i.e. lie them down on one side, then aspirate again

Aspirate paper is - GB Enteral UK pH paper CE marked for human gastric aspirate (available from procurement)

This should be documented on the NG sticker in the patient's medical notes. (See Appendix 2)

Chest X-ray

Patients requiring a Chest X ray to confirm NG placement are as follows:
All patients where aspirate fails or aspirate demonstrates high pH.
All ITU patients Radiography is no longer recognised as the gold standard for determining tube position. Attempts should be made to obtain aspirate before sending the patient for a Chest X-ray.

Chest X-ray is required when no aspirate could be obtained,
pH over 5.5 or patient is on ITU.

Chest X-Ray Request Forms

- Chest X-ray requests must clearly state that the purpose of the chest X-ray is to establish the position of the NG tube
- **X ray should be reviewed as soon as possible after the patients returns to the ward by a registered medical practitioner (i.e. a doctor more senior than a Foundation year doctor, SHO or above)**
- The Doctors must confirmation that the chest X-ray viewed is the most recent and the correct patient
- **The four criteria for confirming gastric placement must be checked on the X-ray and documented on the NG tube insertion record label:**
  - **Following oesophagus,**
  - **bisect carina,**
  - **cross diaphragm in midline and**
  - **pass under diaphragm on left side**
- **Correct placement of the NG Must be documented on the NG sticker in the patients medical notes. (See Appendix 2)**
- Any tube identified as being in the incorrect position must be removed immediately and documented in the medical notes whether in the X-ray department or clinical area. If a misplaced NG tube is noticed by Radiology they will inform the ward. However, as Chest X rays are not always reported immediately, the ward team should not rely on radiology to ensure placement.
- Please note a compentency package is being put together and will be available on ESR, this will become an essential part of mandatory training when available, and the guidelines updated accordingly.

Securing the tube once correct position is confirmed

- Using a suitable fixation tape, secure the tube to the nose and cheek in a manner that keeps it out of the patients' field of vision and avoids friction to the nose.
- The tape should form a bridge between the tube and the skin to reduce skin traction.
- A thin piece of granuflex may be placed under the NGT on the cheek over which the NGT can be taped, this may help to reduce skin irritation especially if the tube is to be in place for some time
- Suitable tapes include, NGT Coverlet and Micropore

Documentation

At the end of the procedure document the following in the medical notes using the trust NG tube insertion record Label (Appendix 2)

- Date and time of procedure
- Size and make of tube inserted
- Length of tube extending from nostril
- How tube position confirmed:
  - **Aspirate confirmation and 2 signatures**
  - **Sticker signed in the appropriate place by a clinican to confirm NG position on Chest X ray**
- How patient tolerated procedure
- Name and signature of practitioner undertaking the procedure.
- Use the maintenance record chart WR4549 to document the on-going care of the patients' nasogastric tube.

SECTION 3 NASOGASTRIC TUBE CARE AND ON-GOING PLACEMENT CHECK

Positioning and reducing the risk of aspiration

Once the NG tube is secure and position confirmed then feeding may commence as per feeding regimen.

- Tube position must be checked at least once in every 24 hours, before commencing new feed and before administering medicines. This may be done by aspirating a small amount of gastric contents and rechecking pH using pH indicator paper. This should be documented on the maintenance record chart.

- If the patient is on any antacid medication. It is important to note that the pH may be altered if the patient's feed or antacid medication has been taken within the past hour, 30ml of AIR should be passed down the tube to clear it of any substance that might falsify the pH result

- If the patient vomits or coughs violently, the tube position must be rechecked

Patients at greater risk of aspiration

Patients who are at higher risk of aspiration include those with a decreased level of consciousness or decreased mental state, those who exhibit uncooperative behaviour or require frequent naso-tracheal suctioning

For patients at greater risk of feed aspiration naso-gastric tube position must be checked frequently, i.e. every 4-6 hours. To check position withdraw gastric aspirate from the NG tube and check the pH of the aspirate.

In addition to regular checks, tube position should also be checked if the following occur:

- The patient has coughed violently, vomited or retched
- The limiting mark on the tube has moved
- The patient can feel the tube coiled in the throat
- The patient or nurse suspects tube malposition
- Suctioning has been carried out
- The patient NEWS score increases after start of feed

If the patient is bed bound or on an overnight feeding, the head and shoulders should be elevated 30-45 degrees during feeding, ideally 45 degrees and for at least one hour afterwards to maintain gravitational drainage of feed to reduce gastric pooling and reduce risk of aspiration.

Maintain a minimum 30 degrees when washing if feed is running or within 1 hour of it stopping. Do not lie flat while feed running or for 1 hour afterwards.

If needing to lie a patient flat, stop the feed for one hour and document time stopped on fluid balance. It is the responsibility of the healthcare professional to check that the feed has been stopped for I hour before they position a patient flat or less than 30 degrees.

If the patient becomes short of breath or NEWs score deteriorates, the feed should be stopped by the nursing staff and medical assistance sought. The clinician should check for signs of aspiration.

Summary

- Check NG tube position regularly, minimum every 24 hours. Use Nasogastric Tube Management form WR 4549

- Ensure patient is elevated at least 30-45 degrees during feeding and for an hour afterwards. If patient becomes cyanosed stop feed immediately, clear airway and seek medical assistance

- Ensure feed has been stopped for one hour before lying flat (refer to fluid balance chart)

- Make sure suctioning equipment is easily accessible

Carry out regular observations; pyrexia and tachycardia associated with wheezing may indicate feed aspiration

- Assess bowel sounds daily

Post Pyloric Feeding – Nasoduodenal/Nasojejunal Feeding

Indications

Patients who are malnourished or at risk of malnourishment and have either an inadequate or unsafe oral intake with a functional and accessible gastro-intestinal tract **and** either:

- Gastric outflow obstruction
- Gastric stasis
- High aspiration risk

Insertion of nasojejunal tube

Nasojejenal tubes are most commonly placed in endoscopy, but can be placed at the bedside (on ITU), or fluoscopically. These Single lumen tubes are placed post-pylorically beyond the ligament of treitz. They have a measurement at the nose, which will be documented on the endoscopy report at the time of insertion. The position of the tube is confirmed in endoscopy and through X ray confirmation of position. Aspirates do not have a role with these tubes.

Skin Care

Regular skin care will reduce irritation and possible infections

- Wash hands before and after tube care
- Replace fixation tape only when it is dirty or peeling off
- When changing the tape cleanse the skin using mild soap and water and dry thoroughly
- Alter the position of the tape when changing it to reduce the chance of irritation
- **Always avoid using creams and powders as they can damage the tube**
- **Ensure that the patient is not allergic to the fixation tape**

Flushing

All nasogastric tubes require regular flushing to prevent blockage (McAtear et al 1999)

- Sterile water and a sterile 60 ml enteral syringe must be used for flushing the NGT
- The NGT should be flushed with 50 mls of sterile water before starting a feed and when feed is stopped.
- The NGT should be flushed with 30-50 mls of sterile water prior to administering medications and once medication is given
- A 10 ml flush of sterile water should be given in between medications; medications must never be mixed.
- Additional water flushes or larger amounts of water given at each flush may be prescribed to improve hydration.
- Use a 1000ml pack of sterile water as appropriate. Use a fresh pack each day/24hrs. for each patient. Label bottle with patient name date and time opened.

Administration of Medications (See MedPolSOP11)

- Accountability – The prescriber/pharmacist must change the route on the prescription chart to make it clear that medicines are to be given via the NG.
- Patients who need to have medicines administered via the NG tube should have their prescriptions reviewed and their regimen simplified where possible.
- Consult the pharmacist for advice regarding medicine-feed interactions.
- Consideration should be given to using other routes and/or once-daily regimes where possible
- The pharmacist may suggest alternative medicines/routes if there is doubt about the suitability of a medicine to be given via the NG tube.
- Where possible all medications should be prescribed in liquid or soluble tablet form to prevent tube blockage. Some tablets that are not marketed as soluble will disperse in water.
- Discuss any medicine which does not come in liquid form with the medical team and the pharmacist.
- Some liquid medicine preparations can be very thick and should be diluted with an equal volume of water before administration.
- Crushed or opened tablets should be avoided if possible as the particles may adhere to the sides of the tube and there is some exposure to the powder. There are some tablets/capsules that must not be crushed or opened, please consult pharmacist/medical team.
- When administering medications via the tube flush with water before and after. Where more than one medication is given flush with a minimum of 10ml in between each medication. **DO NOT** mix medications together give each medication separately.
- Some medications interact with enteral feed, please contact pharmacist/medical team for advice.

Purple enteral ENFit syringes are used for all patients within The Trust

Infection Control and Safety

- Wash hands and wear gloves.
- All syringes used are single use only.
- Sterile Water - Flushes may be decanted from a 500ml or one-litre bottle of sterile water; however the bottle must be labelled with patient name, must not be shared with other patients and must be discarded after 24 hours.
- Keep exposure to drug powder to a minimum

If unsure about any aspect of medicine administration via the naso-gastric route – please contact the ward pharmacist, or Medicines Information (ext. 30235 Trust wide service)

SECTION 5 ADMINISTERING FEED, REGIMENS AND MONITORING

Enteral feed may be administered through the NGT using the **Flocare Infinity Enteral Feeding Pump** with the Infinity pack giving set following feeding regimen from the Dietitian.

- An **Out of Hours emergency regimen is available (WR4989**) from eZ notes for starting feeds out of hours (Ref: WAHT-NUT-008) which includes management of **Refeeding syndrome risk.**

- A pictorial guide to setting up the feed and giving set to the pump is written on the packaging of the giving set.

- Each pump has an operating instruction booklet attached. Details of error alarms can be found in this booklet or in Nutrition Treatment Pathway or www.nutriciaflocare.com.

- Duration of feeding is tailored to the patient's needs but the standard is 20 hours with 4 hours rest. The rest period allows the gastric pH to reduce helping to protect against infection.

- Additional water may be given by flushes or using Nutrison Sterile Water pack. For flushes and medication use sterile water, using a fresh 1000ml sterile water bottle each day/24hrs. The bottle should be labelled with patient name and time opened.
  Water can be given during the rest period without compromising gastric pH..
  Any fluid used to flush the tube or dilute drugs must be recorded on the fluid balance chart.

- The regimen will be reviewed regularly by the dietitian in liaison with the doctors to meet target nutritional needs and minimising /managing risk of Refeeding syndrome

- Use the WR4549 NG Management Form to ensure patient safety while feeding

(Appendix 3) This includes a two nurse check to ensure the feed to be administered is the correct one.

- Use WR5376 poster to reduce risk of aspiration. **(Appendix 4)**

- If feeding interrupted by nasogastric tube being dislodged, consider the use of an AMT bridle. **Refer to Policy for use of an AMT bridle fixation device to secure NG/NJ tube (WAHT NUT 009)**

- Alternatively, and if more appropriate, consider the use of mittens. **Refer to Application of mittens as physical restraint for patients requiring nasogastric feeding. Use of physical restraint with acute stroke. (WAHT MED 014)**

SECTION 6 TROUBLESHOOTING

After initial position checks, aspiration of an NG and checking pH must also be done

- Prior to any substance such as feed, water, medication being administered
- If there is any doubt of the tube not being in the correct position
- If the patient is coughing, retching or vomiting
- If the recorded ,marked length of the tube has changes
- If the patient displays signs of respiratory distress such as shortness of breath, wheezing, change of colour in the face
- If there has been a decrease in O2 SATs readings

Unable to obtain aspirate:
See appendix 1

If the NG tube becomes blocked:

- If attached to the giving set check the clamp is open
- Attach an empty 60ml ENfit enteral syringe and pull the plunger back to try and unblock the tube
- Massage the tube by rolling it gently between your fingers using small movements only. Start from the end furthest away from the body and work towards the abdomen
- Try flushing with 30 mls of warm water, wait 30 minutes then try again. (check NG is in correct position first)
- **DO NOT** use too much force and do not use any sharp objects to try and unblock tube
- **DO NOT** try to reinsert the guide wire in an attempt to dislodge the blockage
- If tube will not unblock remove and reinsert a new NGT
- Review flushes and medication to prevent repeat blockages

SECTION 7 CONSIDERATION FOR A PEG OR DISCHARGE ON NG FEEDING

Patient Safety
The patient should be discussed at the Nutrition MDT. Information regarding the referral process and Referral form can be found on the intranet: http://nww.worcsacute.nhs.uk/departments-a-to-z/nutrition-mdt/

The MDT will advise whether PEG placement would be appropriate and guide the parent team through the feeding decisions to be made (ref Feeding Decisions Pathway). If for PEG refer to PEG guidelines (WAHT NUT 004).

Very rarely it may be appropriate to discharge a patient with NG feeding. This situation will only arise if artificial nutrition is not thought to be required for very long. Note, nursing homes rarely accept patients on NG feeds and it is not appropriate to arrange palliative or “fast track” discharges with NG tubes.

If training is required the dietitians can liaise with Community nursing teams and training arranged. Patients can be discharged from the Acute trust with an NG insitu, the community hospitals have their own NG policy.

For all patients to be discharged home on NG feeding, a plan must be confirmed on how to manage dislodged tubes prior to discharge. The form: NG care plan for feeding (See attached) must be completed by the medical staff and the Dietitian. A copy should be given to the patient and a copy should be sent to the Nutricia Nurse team. For non-complex patients the nasogastric tube may be replaced in the Community by the Nutricia Nurse team, all other patients will require a return to hospital for replacement as agreed in the care plan. (Appendix 8)

Discharge Procedure
Complete Enteral feeding checklist (Appendix 8)
Dietitian to

- Obtain consent to register patient on Homeward delivery system and organise training on NG care by liaising with Homeward nurse.
- Register with Homeward for feed and ancillary deliveries
- Contact GP for the feed prescription
- Provide feeding regimen on discharge to patient/carer
- Provide contact numbers for Homeward nurse and out of hours Homeward advice line.
- Discuss with patient/carer where feed is obtained post discharge
- Liaise with District Nurse team if necessary)
  Provide an enteral feeding pump and stand (if not delivered prior to discharge)
  DO NOT SEND WARD PUMP
- Handover to Worcestershire Community Dietetic team or GP if destination not covered by community team.

Homeward Nutricia nurse to

- Provide competency based training for patient and carers to be completed by designated carers prior to discharge. Homeward Nurses attending the ward will document training outcome in the medical notes. If training has been done in Nursing home, patients own home or at care agency, Homeward Nurse will report back to Dietitian who will document in the medical notes.
- Nasogastric Tube Advice Leaflet given by Homeward nurse on training.
- Report back to the ward that training is complete or if there are any concerns with competencies

Ward Nurse to

- Provide 7 day supply of 60ml ENfit enteral syringes and any other syringes required for medications
- 7 day supply of giving sets
- Ensure TTO's have been ordered and that a 7 day supply of feed is sent home
- Medications Leaflet (supplied by Pharmacy)
- Plans are in place for replacing an NG tube after 90 days or if it falls out. Homeward Nurse can do this if appropriate paperwork in place (appendix 10)
- Facilitate agreement on any additional support required for discharge, in particular if a package of care is required.
- Facilitate agreement on any additional support required for discharge, in particular if a package of care is required.

Speech and Language Therapist to

- Ensure patient/carer is aware of what oral intake is safe and provide Dysphagia Passport if appropriate
- Confirm if patient is to remain Nil By Mouth
- Provide information on mouth care

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WAHT- NUT -006 Guideline for re-feeding syndrome

WHAT-NUT-004 PEG guidelines

WHAT-NUT-009v1.5 Nasal fixation device guidelines

WHAT-NUT-008 Out of hours feeding guidelines

Monitoring Tool

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
Appendix 2	Completion of the "Nasogastric Tube Insertion Record Label.	Audit of completion of the Nasogastric tube Insertion Record label in medical notes	5/month until 100% compliance for 6 months then annually	Ward Sister's and Matrons Stroke Unit	Nutrition & Hydration Steering Committee	Monthly till 100% compliance then annually
Data Collection and audit	Numbers of staff trained and registered as competent with the training department	Analysis of electronic reporting function on OLM and on ESR	6 monthly	Professional development and training department	Nutrition & Hydration Steering Committee	January and July

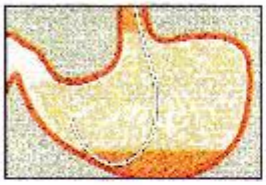
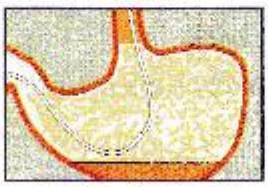
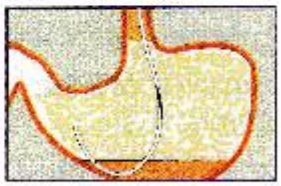
APPENDIX 1 ASPIRATION GUIDE

Aspiration guide

Because tubes are passed blind the reasons why no aspirate can be obtained are not obvious.

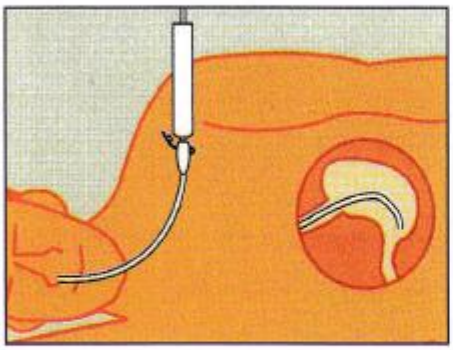
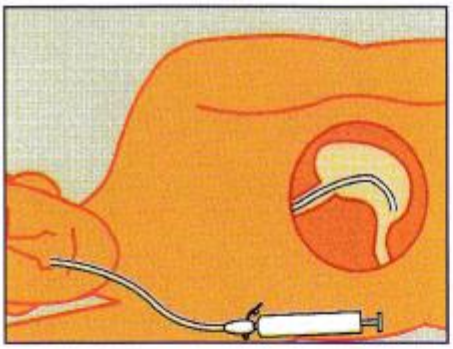
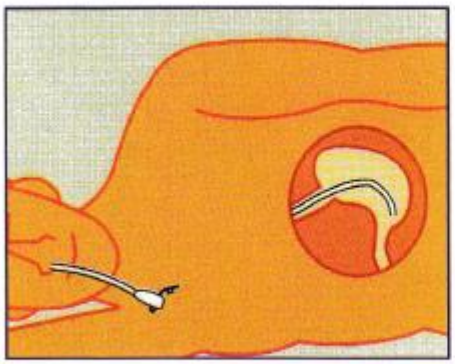
The most common reasons are illustrated below, which can be eliminated one by one by using the guide.

Aspirate should be obtained in most cases (93%).

TUBE ABOVE FLUID LEVEL	TUBE IN OESOPHAGUS	TUBE OCCLUDED IN MUCOSA
		
Advance or withdraw tube 5cm or aspirate with smaller syringe. Put patient on left side. ASPIRATE	Inject 20ml of air with a 20ml syringe. If the patient belches immediately tube is in the oesophagus. ASPIRATE	Inject 20ml of air, try smaller syringe, put patient on left side, try to aspirate again. ASPIRATE
NO FLUID IN STOMACH	**TUBE IN SMALL BOWEL**	**TUBE OCCLUDED**
		
Having injected air and tried smaller syringe, wait 15-30 minutes then try again with the patient on their left side. ASPIRATE	pH will normally be 6-8 and bile will usually be present. Withdraw tube 10-20cm in adults and 5-10cm in children & retry. ASPIRATE	Tube may be kinked or occluded with debris. Inject 20ml of air (10ml in children) & retry. ASPIRATE

COMMON SOLUTIONS

Common solutions

	Inject air, try smaller syringe, advance and withdraw tube ASPIRATE
	Try syringe below the level of stomach to siphon aspirate ASPIRATE
	Change patient's position on to their right side ASPIRATE

APPENDIX 2 NG TUBE INSERTION RECORD LABEL XEROX073

NG Tube Insertion Record and Safety Standards Sticker

Insertion Date ..... /..... /..... Time: .....

NG Tube inserted by: Name: ..... Sign: ..... NMC/GMC: ..... Role: .....

For use in all cases where NG Tube is inserted. Apply into patients notes.

Pre-procedure check:

Check:

1. Patient identification confirmed ☐

2. Consent: Verbal ☐
   Written ☐
   Best interest decision ☐
   (Power of Attorney / NOK informed) ☐

3. Is the medical request for NGT documented in notes:
   Tick indication:
   Medication administration ☐
   Feeding ☐
   Drainage ☐

4. Nose-ear-Xiphisternum length: cm

5. Are the appropriate staff and equipment available to insert and confirm NG tube? ☐

Procedural record:

Patient put into optimal position (sit upright with head supported) ☐

Nostril used: Right Left

Number of attempts .....

NB tube size: .....Fr

Length of NGT at nostril once secured ..... cm

DO NOT ADMINISTER ANYTHING UNTIL GASTRIC PLACEMENT CONFIRMED

IF NG TUBE IS DISPLACED:

- **DOCUMENT IN NOTES**
- **USE NEW STICKER FOR EVERY NEW NGT INSERTED**

Gastric Placement Check:

NGT aspirate obtained?

☐ Yes ☐ No

Is aspirate pH between 1-5.5? Yes No

Confirm with registered colleague:

2nd practitioner sign: .....

2nd practitioner NMC: .....

Safe to start feeding? Yes No

Is chest X-ray required? Yes No

(i.e. ITU / no aspirate obtained / pH over 5.5)

Confirm most current X-ray viewed: ☐

Does NG Tube:

Follow oesophagus? Yes No

Bisect carina? Yes No

Cross diaphragm in midline? Yes No

Pass under diaphragm on left side? Yes No

IF THERE IS ANY UNCERTAINTY SEEK SENIOR OR RADIOLOGY ADVICE

X-ray interpreted by:

Cliniician name:

Clinician sign:

Clinician GMC:

Date: Time:

Safe to start feeding? Yes No

Begin regular position checks as per Policy

Re-order code: Xerox073

NG Tube Insertion Record and Safety Standards Sticker

Insertion Date ..... /..... /..... Time: .....

NG Tube inserted by: Name: ..... Sign: ..... NMC/GMC: ..... Role: .....

For use in all cases where NG Tube is inserted. Apply into patients notes.

Pre-procedure check:

Check:

1. Patient identification confirmed ☐

2. Consent: Verbal ☐
   Written ☐
   Best interest decision ☐
   (Power of Attorney / NOK informed) ☐

3. Is the medical request for NGT documented in notes:
   Tick indication:
   Medication administration ☐
   Feeding ☐
   Drainage ☐

4. Nose-ear-Xiphisternum length: cm

5. Are the appropriate staff and equipment available to insert and confirm NG tube? ☐

Procedural record:

Patient put into optimal position (sit upright with head supported) ☐

Nostril used: Right Left

Number of attempts .....

NB tube size: .....Fr

Length of NGT at nostril once secured ..... cm

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☐ Yes ☐ No

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Confirm with registered colleague:

2nd practitioner sign: .....

2nd practitioner NMC: .....

Safe to start feeding? Yes No

Is chest X-ray required? Yes No

(i.e. ITU / no aspirate obtained / pH over 5.5)

Confirm most current X-ray viewed: ☐

Does NG Tube:

Follow oesophagus? Yes No

Bisect carina? Yes No

Cross diaphragm in midline? Yes No

Pass under diaphragm on left side? Yes No

IF THERE IS ANY UNCERTAINTY SEEK SENIOR OR RADIOLOGY ADVICE

X-ray interpreted by:

Cliniician name:

Clinician sign:

Clinician GMC:

Date: Time:

Safe to start feeding? Yes No

Begin regular position checks as per Policy

Re-order code: Xerox073

APPENDIX 3 WR4549 NG MAINTENANCE RECORD CHART

Affix Patient Label here or record:

Name: . . . . . .

NHS No: | | | | | | | | | | |

Hosp No: | | | | | | | | | | |

D.O.B: D D / M M / Y Y Y Y Male ☐ Female ☐

Ward:..... Cons:.....

NASOGASTRIC TUBE MANAGEMENT AND ENTERAL FEED CHECK RECORD

NHS Worcestershire Acute Hospitals NHS Trust

All NG tubes must be checked for correct position as follows (this involves aspirating and pH testing):

(A) Routine check at least every 24hrs. (4-6hrs for patients at greater risk of aspiration).
(B) Starting a new bag of feed.
(C) Administration of medication.
(D) Patient complained of discomfort of feed reflux into the throat or mouth.
(E) Evidence of coughing or shortness of breath whilst feeding.
(F) Patient vomited / has violent retching / severe coughing bouts
(G) Following endotracheal tube or tracheotomy suctioning
(H) The length of the visible portion of the NG tube is noticeably longer.
(I) The measurement on the tube is not the same as the measurement originally recorded
(J) Other - please provide the reason.

Date						
Time						
NG tube still indicated (Yes / No)						
Reason for pH testing (see codes above)						
pH result (acceptable range is 5.5 or less. Be mindful of medication that can alter the pH value)	pH=	pH=	pH=	pH=	pH=	pH= .....
Position of NG - cm at nostril Please compare with Insertion record	.....cm	.....cm	.....cm	.....cm	.....cm	.....cm
Tube fixation clean and intact (yes / No)						
Nasal area Checked for erosion (Yes / No)						
Patient observations stable (Yes / No)						
30 - 45 degrees Semi-recumbent patient position maintained to aid feed absorption (Yes / No / N/A)						
NG tube flushed with sterile water (NG tube can only be flushed following verification of placement) (Yes/ No / N/A)						
Feed check (if applicable). Correct feed Correct rate (Yes/ No / N/A)						
Name and Title of Practitioner (Print)						
Signature of Practitioner						
Second checker signature						

For Proof Do Not Use

PF WR4549 Nasogastric Tube Management And Enteral Feed Check Record Version 3 Page 1 of 2

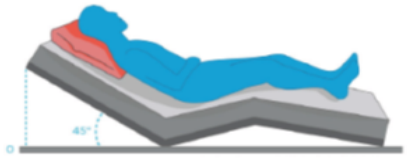
For Proof Do Not Use

Appendix 4
Laminated Posters A5 size available from Xerox WR5376

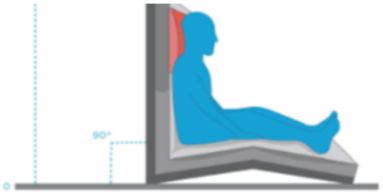
NHS Worcestershire Acute Hospitals NHS Trust

Implement the following to reduce risk of aspiration for patients on an enteral feed:

- Position patient at 30 - 45 degrees in bed or 90 degrees in bed or in a chair during feeding and for one hour after feeding has stopped.



30 - 45 degrees



90 degrees

- Doctors & health care professionals to look at fluid balance chart to check feed has been stopped for 1 hour before lying patient flat/less than 30 degrees to carry out treatment.
- For personal care, use appropriate manual handling techniques whilst maintaining a 30 degree minimum patient position.
- Contact dietitian to agree suitable times/length for feeding in day time to facilitate above.
- Maintain a semi-upright position of 30 – 45 degrees whilst sleeping.
- Maintain oral hygiene to reduce risk of infection by using the oral care assessment tool.
- Refer to Naso gastric/PEG regimen and guidelines on the intranet for more information.

WR5376 Version 3 January 2019

Appendix 5

ADMINISTERING DRUGS VIA ENTERAL FEEDING TUBES
A PRACTICAL GUIDE

UNLICENSED ROUTE

Crushing tablets, opening capsules, and administration via feeding tubes generally falls outside a drug's product licence. **In these circumstances the prescriber and practitioner accept liability for any adverse effects resulting from this administration.**

TUBE TIP POSITION

- Check the drug is absorbed from the site of delivery.
- This can be a problem for jejunal tubes (some drugs have a reduced absorption).

WHICH TYPE OF WATER?

- Check local policy
- The type of water recommended depends on local practice and the exit site of the tube.

SYRINGE TYPE AND SIZE?

- Use the appropriately sized SINGLE USE DISPOSABLE oral medication syringe (with purple barrel or plunger) for the volume of medication required
- When using small size syringes do NOT exert more than minor pressure on the plunger to avoid rupturing the tubing or the enteral device
- Do not use syringes intended for intravenous use due to the risk of accidental parenteral administration.

INFECTION CONTROL AND SAFETY

- Wash hands and wear gloves.
- It is important that exposure to drug powder is kept to a minimum+.

TUBE BLOCKAGE

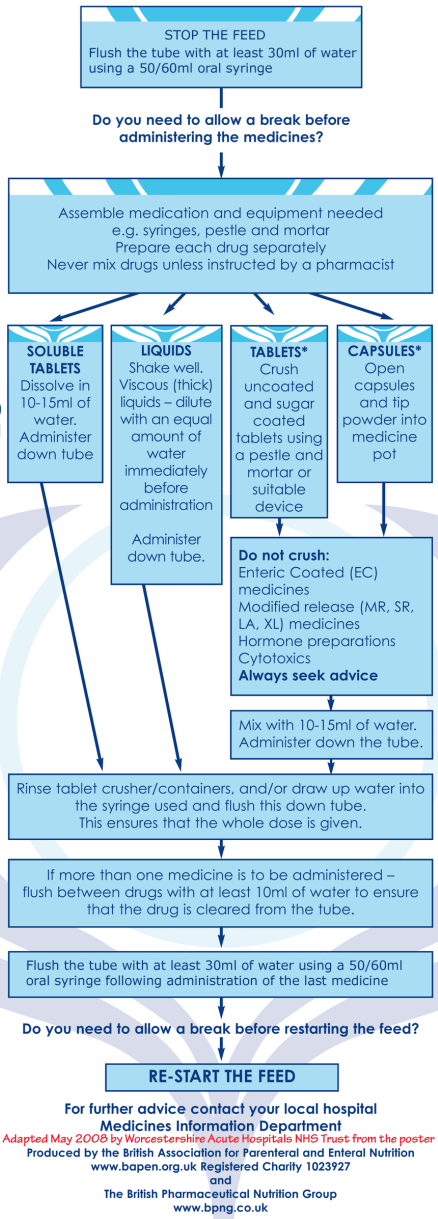
- Inadequate flushing is the most common cause of tube blockage.
- Using the wrong formulation of medication can also cause tube blockage.
- If flushing with warm water does not unblock the tube, seek specialist advice, do not apply excessive force.

DISCHARGE PLANNING

- Ensure the agreed feed and drug regimen are practical in a community setting.
- Ensure all necessary information is given to the community pharmacist and GP.

STEP BY STEP GUIDE

- **Can the patient still take their medication orally?**
- **Do not add medication directly to the feed**
- **Seek further advice for fluid restricted or paediatric patients as flushing volumes may need to be reduced**
- **Review all medication. Is it all really necessary?**
- **Can an alternative route be used?**



For further advice contact your local hospital Medicines Information Department

Adapted May 2008 by Worcestershire Acute Hospitals NHS Trust from the poster

Produced by the British Association for Parenteral and Enteral Nutrition
www.bapen.org.uk Registered Charity 1023927
and
The British Pharmaceutical Nutrition Group
www.bpng.co.uk

PREFERRED FORMULATIONS

- Liquids or soluble tablets are the preferred formulations to be administered via a feeding tube.
- Some injections can be given enterally.
- ***Crushing tablets or opening capsules should be considered as a last resort.**

MEDICINES THAT SHOULD NOT BE CRUSHED

- Enteric Coated (EC): The coating is designed to resist gastric acid to protect the drug and/or reduce gastric side effects.
- Modified/Slow Release (MR, SR, LA, XL): These are tablets or capsules that are specifically designed to release the drug over a long period of time. Crushing these will cause all the drug to be released at once and may cause toxic side effects.
- + Cytotoxics & Hormones: These should not be crushed due to the risks to staff from exposure to the powdered drug.

INTERACTIONS

Interactions between feed and drugs can be important. Always check with your pharmacist before administering any medication via a feeding tube.
Where possible give dose during a break in the feeding regimen to minimise this.

Problem Drugs

- **Phenytoin, Digoxin and Carbamazepine:** Blood levels may be affected by feeds, these should be checked regularly. It may be necessary to increase the dose.
- **Antacids:** The metal ions in the antacids bind to the protein in the feed and can block the tube. Consider using alternative drugs.
- **Penicillins:** Feed may reduce the absorption, a higher dose may be needed. If possible stop feed 1 hour before and 2 hours after administration.
- **Other antibiotics:** Levels of antibiotics such as ciprofloxacin, tetracyclines and rifampcin can be significantly reduced by feed.
- Consider other alternatives or increase doses.

(This list is not exhaustive).

Originally Sponsored by Educational Grant from Baxa Ltd, Fresenius-Kabi Ltd, Merck Gastroenterology, Nutricia Clinical Care, Rosemont Pharmaceuticals Ltd, Tyco Health Care.

Appendix 6 Enteral feeding Discharge Checklist

	NURSING STAFF	Initials
1)	Inform Dietitian of Expected Date of Discharge and place of discharge	

	DIETITIAN	
1)	If not being discharged within Worcestershire liaise with their local Dietitians.	
2)	Obtain **consent** to pass on patient details to Homeward.	
3)	Organise **training** for carers/patient on use of equipment.	
4)	Confirm date of training …… Confirm training completed.	
5)	Write to GP **re prescriptions** for feed, confirming if NBM and if feed meets full nutritional and fluid needs.	
6)	**Register** patient on Homeward for on-going supplies equipment.	
7)	Provide **Homeward feeding pump and drip stand** if required for feeding.	
8)	Provide community feeding **regimen** for patient/carers with contact details and a texture modified diet sheet if needed.	
9)	Confirm **discharge plan** is in place to Ward Manager for Nursing staff to organise TTOs from Ward stock.	
10)	Transfer care to community dietitians/GP.	

	NURSING STAFF CRITERIA FOR DISCHARGE WHEN MFFD	
1)	**Feed**: Ensure 7 day's supply available at time of discharge. Ensure feed added to EDS prescription list.	
2)	**Equipment**: Provide 7 day's supply of giving sets and 60ml enteral syringes compatible with feeding tube.	
	For those on NG/balloon gastrostomy/RIG: pH indicator and spare tube	
3)	**Regimen** Check patient has feeding regimen provided by dietitian This includes contact numbers for Homeward Nurse, pump advice line and Community Dietitian.	
4)	**Training** Confirm patient / carer has been taught how to administer feed.	
5)	Check patient / carer knows how to **care for PEG site** to prevent buried bumper and infection and prevent tube from blocking by flushing.	
6)	Check patient has PEG booklet.	
	For NG/NJ/Jejunostomy feeding tube: appropriate booklet for tube care	
7)	**Oral** Check yellow swallowing recommendations bed sign is sent with patient on discharge if applicable.	
	If NBM: confirm oral mouth care plan	
8)	Check patient has a supply of Nutilis Clear if used. Check added to EDS prescription list.	
9)	Ring **carers** to notify of planned date of discharge.	

Appendix 7

Discharging a Patient Home on an NG Tube Feed

Complete NG Position Record Form when tube is inserted
Monitor:

- pH aspirates
- Toleration to feed
- Refeeding bloods (if required)
- Weight

↓

Contact Dietitian to arrange Homeward Nurse for training

↓

If patient / carer assessed as competent to care for NG tube at home – discharge date can be planned

If patient / carer assessed as **not** competent to care for NG tube at home – discharge is unsafe. Consider organising a package of care, community hospital or nursing home

↓

- A plan must be in place for what to do if the NG tube becomes displaced - notify the patient / carer what to do if the tube is displaced.
- Dietitian will register the patient with Homeward for monthly delivery of ancillaries

If NG tube feeding likely to continue for longer than 4 weeks consider PEG/RIG/JEJ placement if appropriate

↓

Patient to take away:

- Feeding regimen
- NG Care plan (Bluespier)
- NG care passport (Nutricia)
- NG care information booklet
- Contact number for Dietitian and Homeward Nurse
- Details of what to do should the tube become displaced
- Equipment as required (7 day supply) – Pump, stand, giving sets (supplied by Dietitian)
- Ward to supply 7 day supply feed and syringes,
- Ward to also supply spare tube, pH paper and tape to secure tube in position if the patient has not had a Homeward delivery before the day of discharge

Appendix 8 Naso Gastric Tube (NGT)Care Plan for Feeding in the Community

<Patient: Name>,	<Patient: Date of Birth>
NHS No: <Patient: NHS Number>	<Patient: Hospital Number>
<Patient: Address Line>	

Relevant past medical history: Allergies: yes /No / Unknown	
Patient Nil By Mouth: yes / No	
Medication: PPI (Omeprazole/Lansoprazole/Zoton) YES / NO Anticoagulation (Warfarin)/ other YES / NO	
Reason for NGT feeding:	
Date Inserted:	Length of tube inserted (NEX): cm
Most recent pH readings:	Name of second competent checker:

Section 2 **Plan for replacement of NGT on discharge; if dislodged or routinely required**

Does the patient have any medical contraindications to the tube being passed in the community? e.g. oesophageal varices/pharyngeal pouch/upper GI anatomical changes/head and neck cancer/basal skull or nasal fractures (NB list not exhaustive)	*YES / NO
*If YES please specify Patient will need to return to for tube replacement: Ward / A&E	
If the tube becomes dislodged out of hours can they wait 24-48 hours for the tube to be replaced: Yes / No If No follow advice from hospital discharging team as agreed prior to discharge:	
Or can this tube be repassed in the community by a trained Nurse if routinely required, blocked or unable to obtain gastric pH?	YES / NO
Spare NGT provided on discharge	YES / NO

Section 3 **Useful contact numbers- see Dietitians feeding plan for contact details**

Completed by:
Print name and role:…… Date: <Todays Date>

- **Please print copy for patient**
- **Email Copy to Nutricia Nurse contacted for training.**
- **Email copy to Worcestershire Community Dietitians**

CONTRIBUTION LIST

Key individuals involved in developing and updating document

Name	Designation
Carl Robinson	Team Leader Dietitian WAHT
Sarah Pritchard	Senior Dietitian, WAHT
Katie Troth	Community dietitian
Dr Thea Haldane	Consultant Gastroenterologist WRH
Jon Howard	Nutrition & Hydration Lead, Professional Development
Sarah Empson	Highly specialist Speech and Language Therapist Acute inpatient lead
Keith Hinton	Principal Pharmacist Medicines Safety
Juliette Hawkesford-Barnes	Matron specialty medicine
	Matron Head and Neck
	Patient safety and Risk Manager

Circulated to the following individuals for comments updated version

Name	Designation

Circulated to the following CD's/Heads of dept for comments from their directorates / departments

Name	Directorate / Department
Morag Ingles	Nutrition and Dietetics Manager

Circulated to the chair of the following committee's / groups for comments

Name	Committee / Group
Claire Hubbard	Nutrition & Hydration Steering Committee
Keith Hinton	Medicines Safety Committee

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Nasogastric Feeding Tube Insertion and Care-Adult			
What is the aim, purpose and/or intended outcomes of this Activity?	See body of document			
Who will be affected by the development & implementation of this activity?	❑ ❑x ❑ ❑	Service User Patient Carers Visitors	❑x ❑ ❑ ❑	Staff Communities Other _____
Is this:	❑ x Review of an existing activity ❑ New activity			

	❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		x		
Disability		x		
Gender Reassignment		x		
Marriage & Civil Partnerships		x		
Pregnancy & Maternity		x		
Race including Traveling Communities		x		
Religion & Belief		x		
Sex		x		
Sexual Orientation		x		
Other Vulnerable and Disadvantaged Groups (e.g. carers;		x		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
care leavers; homeless; Social/Economic deprivation, travelling communities etc.)				
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		X		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	N/A	.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	N
2.	Does the implementation of this document require additional revenue	N
3.	Does the implementation of this document require additional manpower	N
4.	Does the implementation of this document release any manpower costs through a change in practice	N
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	N
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.