Neonatal and Paediatric Guideline for Enteral Tube Insertion

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Approved by:	Paediatric Quality Improvement Meeting 15th September 2021, MSC 12th January 2022	
Date of Approval:	12th January 2022	
Date of Review: **This is the most current version and should be used until a revised document is in place**	10th May 2026	

Key Amendments

Date	Amendments	Approved by
10th November 2025	Document extended for 6 months to allow time for review and update	Susan Smith

Introduction

This guideline provides an evidence based guide for healthcare professionals on how to insert and confirm correct placement of enteral tubes to provide safe enteral feeding in neonatal and paediatric patients.

This guideline sets out the safe practice that must be followed in regards to enteral tube management at Worcestershire Acute Hospitals NHS Trust.

This guideline can be used in conjunction with the **Neonatal and Paediatric Guidelines for Safe Use of Enteral Tubes**.

For the purpose of this document the term '**enteral tubes**' is used to mean nasogastric and orogastric tubes only.

For neonatal and paediatric patients, Worcestershire Acute Hospitals NHS Trust (WAHT) only allow for the insertion of **nasogastric** and **orogastric** tubes in ward areas. Other kinds of enteral tubes (i.e. gastrostomy and jejunal) may be inserted in other Trusts and then be safely used on the ward areas at WAHT.

Patients covered

This guideline is applicable to any neonatal or paediatric inpatient requiring an orogastric or nasogastric tube and on whom it is safe to pass these tubes.

'Neonatal' includes any inpatient on the neonatal unit or any patient under neonatal care.

'Paediatric' includes any patient from the age of birth until 18 years old, who is an inpatient on any paediatric ward/area or under a paediatric team.

For policies in the community, please see Neonatal Outreach or Orchard Service guidelines.

Outcomes of policy

- To provide guidance towards appropriate, competent and safe insertion and use of enteral tubes.
- To minimise morbidity and prevent complications and incidents associated with enteral tube use.
- To provide information and rationale on enteral tube competencies for relevant staff.

This guideline is for use by the following staff groups:

Registered nurses, doctors, healthcare assistants and nursery nurses who have been assessed to be competent in these skills.

Duties and responsibilities

- **Ward Managers and Sisters** are responsible for ensuring that all nursing staff (including non-registered staff) are aware of this policy and follow the safe practice within it.

- **Consultants** are responsible for ensuring that medical staff are aware of this policy and follow the safe practice within it, particularly around ordering and interpreting x-rays.

- **Radiographers** are responsible for ensuring that the feeding tube can be clearly seen on this x-ray if a check for feeding tube position check is requested.

- **All clinical staff** are responsible for following this policy and reporting any adverse events via Datix. Staff who assess the position of feeding tubes must undertake the mandatory training outlined in Section 2.

- **The Compliance and Governance Manager** is responsible for uploading all policies and strategies approved by the Policy Approval Group.

Contents

Section 1 - Introduction to enteral tubes.

Enteral tubes are a means of offering additional nutritional support in neonates and children who cannot adequately meet their nutritional needs by oral feeding alone. Enteral tubes can also be used for ease in administering medications; or may be inserted to help with gastric drainage, for example with some post-operative and critically unwell patients.

This guideline mostly focusses on **nasogastric** tubes as the main method of enteral feeding as this is the first choice for feeding tubes in neonates and paediatrics. An **orogastric** tube may be passed and used in a similar way to a nasogastric tube if it is deemed unsuitable to pass a nasogastric tube.

It is common to use GBUK 'Nutricare' or 'Nutricare Infant' enteral tubes as these tubes can be left in situ for up to 90 days.

It is uncommon to use Ryle's tubes in children and neonates for gastric drainage; instead an enteral tube is used with a GBUK enteral drainage bag attached. Ryle's tubes must **NEVER** be used for feeding or administration of medicines.

Enteral tube 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. It is important that it is **clearly documented** by a member of the medical, nursing or dietician team what the enteral tube is to be used for and for how long it is expected to be required.

Section 2 - Competencies Required.

Insertion of enteral tubes should be carried out by registered nurses and doctors who have been deemed competent to do so (National Institution for Health and Care Excellence, NICE 2017) using the **Neonatal and Paediatric Nasogastric Tube Insertion Competency Framework.**

Student nurses and student doctors may insert nasogastric and orogastric tubes only under direct supervision of a registered nurse or doctor who is fully competent in this skill.

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

Training for the insertion, use and care of enteral tubes will be given by competent senior nursing staff. Once initial training has been completed, the practitioner should carry out at least three successful insertions under the supervision of a competent senior nurse before being deemed competent.

Section 3 – Assessment for need of enteral tube.

Reason for enteral tube placement

It is essential that the reason and rationale for enteral tube placement and its purpose is clearly documented in the medical notes, with support from the MDT i.e. dieticians, if appropriate, with a clearly stated feed regime.

- The estimated time frame / duration of use should be specified.
- Evidence of informed consent from patient / parent / carer as appropriate.
- It should be documented which members of the MDT are expected to be involved in the child's care of the enteral tube; for example named consultants / paediatricians, dieticians, community nurses, etc.

Table 1 – Indications for enteral nutritional support in infants and children

Indication	Examples of clinical conditions
Unsafe or unable to swallow.	Cleft lip /palate, cerebral palsy, requiring invasive ventilation, congenital abnormalities
Poor suck	Prematurity, neurological conditions
Increased nutritional requirements	Cystic fibrosis, congenital heart disease, bronchiolitis
Poor appetite secondary to illness	Oncology patients, liver disease, renal failure
Malabsorption	Short bowel syndrome, Necrotising Enterocolitis
Unpalatability of specialised feeds or medicines	Inflammatory Bowel Disease
Continuous supplement of nutrients required to prevent hypoglycaemia	Glycogen Storage disease Type 1
Reduced oral intake due to mental health	Anorexia Nervosa

Informed consent

For all neonatal / infant / child patients; consent must be obtained from parent/carer with parental responsibility, ensuring that they have been involved in discussions regarding the enteral tube and have been informed about the procedure and the risks/benefits of having an enteral tube.

The following information should be discussed:

- Proposed benefits of treatment specific to the child, i.e. weight gain, ease of medicine administration, drainage of gastric juices, safe feeding, etc.

- All possible risks and complications of treatment, i.e. infection, gastro-oesophageal reflux, tube migration, vomiting, retching, etc.
- The impact of tube feeding for the child and family, i.e. body image, restricted freedom, stress of enteral feeding, impact on social aspect of family life
- The impact of the tube on the child's carers or school and the need for training.

In the case that you are unable to gain consent from parent/carer with parental responsibility in an emergency situation (ensuring every effort is made to gain consent), practitioners must work within the child's best interest.

In the case of older children and young people, practitioners must assess that the child / young person is deemed to be Gillick competent with regards to whether they can themselves consent for the procedure.

In the case of older child / teenagers that do not consent but it is medically vital they have an enteral tube, it might be appropriate to consider a Mental Health Act assessment.

In all children and young people that are able to communicate but not necessarily consent, ensure they are informed of the procedure and an effort is made to alleviate any anxieties or worries. If appropriate, seek play specialist input.

In neonates and infants, if appropriate, effort should be made to ensure infant is in a safe position for enteral tube insertion and feeding, i.e. in a gentle swaddle. Mittens may be appropriate to try to prevent accidental removal of the tube.

Section 4 – Insertion of enteral tube.

- The enteral tube **must not** be lubricated prior to insertion as it can alter the pH reading and block holes at the tip of the nasogastric tube.

- All feeding tubes must be radio-opaque throughout their length and have externally visible markings.

- For nasogastric tubes, the tube diameter should not obstruct more than 50% the diameter of the nostril. If a patient has previously had a nasogastric tube, it is advisable to change to a different nostril as to rotate placement sites.

Orogastric feeding may be considered in patients where a nasogastric tube cannot be placed due to physical reasons (i.e. nasal trauma, nasal abnormalities, basal skull fracture) or due to the treatment the child is receiving (i.e. CPAP). This should be discussed with the medical team.
This tube is tested and managed in the same way as a nasogastric tube but the tube is inserted into the stomach via the mouth and is secured to the chin.

A nasogastric tube rather than an orogastric tube should always be inserted unless there is a documented contra-indication to this procedure, as the risks of tube migration are lessened.

Precautionary measures when undertaking enteral tube insertion:

Seek Medical advice in the following instances before inserting an enteral tube:

- Previous attempt at enteral tube insertion was difficult or with complications.
- Recent surgery to face, head or neck.
- Neurological problems causing an increased risk of aspiration such as low GCS / consciousness.
- Head injury / Spinal or neck trauma.
- Congenital abnormalities to face, head or neck.

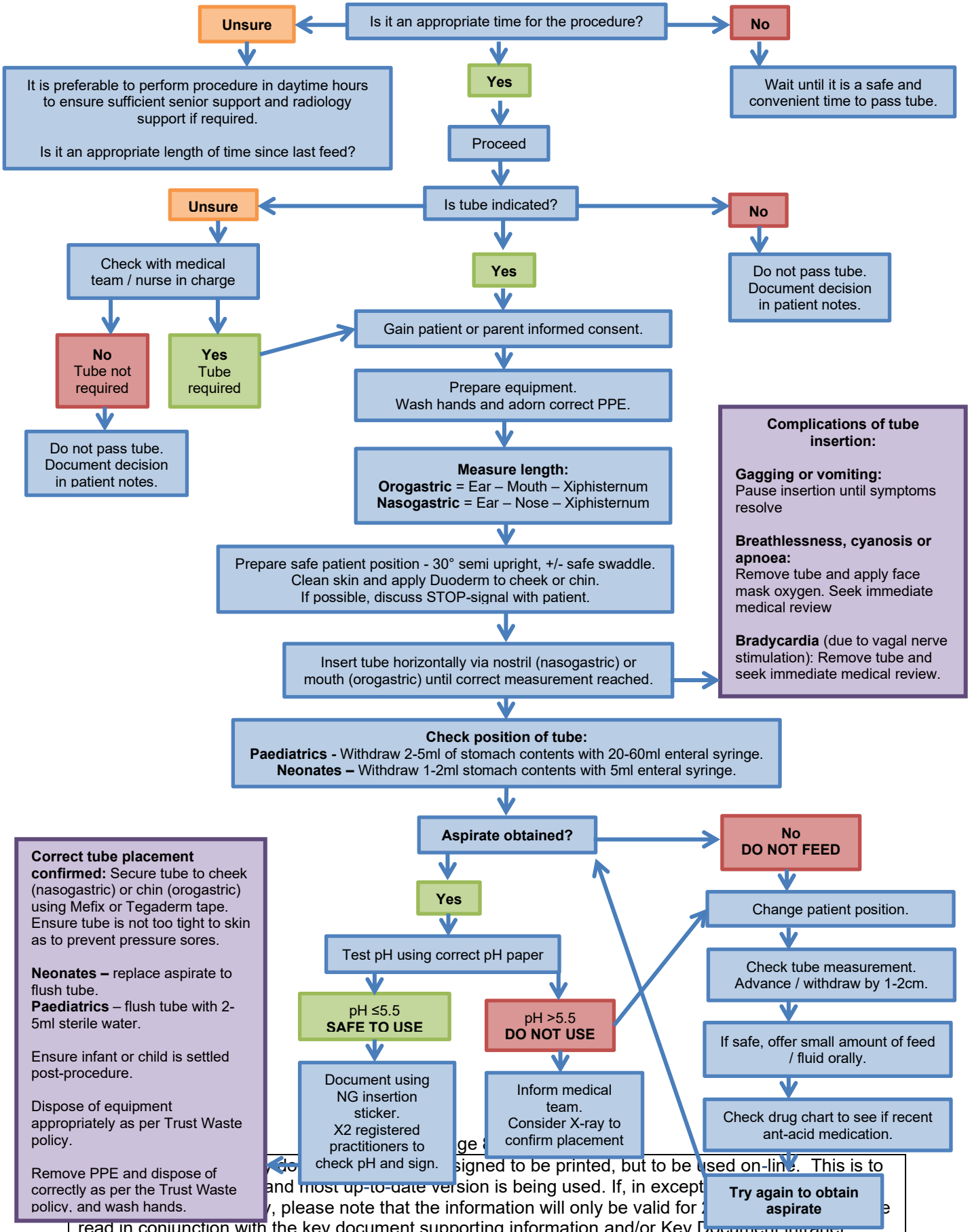
Aims of carrying out procedure:

- To provide adequate nutrition.
- To maintain patient safety.
- To ensure comfort and co-operation of the patient.
- To monitor patients for complications of enteral feeding.
- To administer feeds and medicines as per patient plan.

Equipment needed for procedure:

- GBUK Enteral Nutricare or Nutricare Infant nasogastric tube with ENFit ISO 80369-3 Connector +/- guidewire, 90 days use, fully radiopaque.
- Tube length and diameter appropriate to patient size.
- pH indicator paper, CE marked for use with human gastric aspirate.
- Non-sterile gloves.
- **In Paediatrics – 20 - 60ml oral/enteral (purple) syringe for aspirating.**
  In Neonates – 5 - 10ml oral/enteral (purple) syringe for aspirating.
- Sterile water for flushing (**Paediatrics only**).
- If applicable, drinking water and straw for swallowing.
- If applicable, sucrose/EBM to manage pain/discomfort. Administered via buccal route.
- Fixative tape i.e. tegaderm, Mefix.
- Duoderm.
- Nasogastric Tube Insertion Record and Safety Standards sticker (**Appendix 1**).

Flowchart for the insertion of nasogastric and orogastric tubes



Section 5 - Confirming tube position.

The position of the tube in the stomach must be confirmed before anything can be introduced down the tube. The two methods for confirming tube position is **Aspiration** and **X-ray**. 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 (Cannaby et al, 2002, National Patient Safety Agency 2011).

Nasogastric tubes must never be flushed or used before gastric placement has been confirmed. Severe harm or death from misplaced nasogastric tubes is deemed a 'never event' (National Patient Safety Agency, NPSA 2012).

Aspiration

Correct tube placement is confirmed by aspirating a small amount of gastric contents and checking the pH using suitable pH indicator paper. This value should be **≤5.5**.

Paediatrics - A 20-60ml enteral syringe should be used to aspirate 2-5ml of gastric contents.

Neonates - A 5-10ml enteral syringe should be used to aspirate 1-2ml of gastric contents.

In Neonatal patients, if the tube has been confirmed as being in the stomach, it is routine to replace the aspirated stomach contents. This is to minimise fluid loss.

In Paediatric patients, it is common to flush the tube with 2-5ml sterile water once correct placement has been confirmed.

If unable to obtain aspirate:

- Reposition patient – lay patient on left side for 10-20 minutes if possible and re-aspirate tube. If unsuccessful, try moving patient between left and right side and into an upright position then re-aspirate.
- Check tube measurement at edge of nose/lips. Advance or withdraw tube 1-2cm and re-aspirate tube.
- If safe to do so, offer patient small amounts of fluid or feed orally then re-aspirate tube.
- Check drug chart to see if patient receives anti-reflux or anti-acid medicines and perform appropriate risk assessment / discuss with medical team.

X-ray confirmation

Radiography is no longer recognised as the gold standard for determining tube position and should be used as a **second line intervention**. Attempts should be made to obtain gastric aspirate before sending the patient for x-ray.

Chest X-ray is required when no aspirate can be obtained or pH is consistently over 5.5.

The x-ray request form must clearly state that the purpose of the x-ray is to establish the position of a gastric or jejunal tube for the purpose of feeding or medication administration.

The radiographer must take responsibility for ensuring that the feeding tube can clearly be seen on the x-ray. The x-ray must only be interpreted by clinicians who have been deemed competent in assessing the position of feeding tubes by x-ray.

The assessment of feeding tube placement must be documented in the patient's medical notes and must include:

- Confirmation that the x-ray viewed was the most recent for that patient.
- The length of the feeding tube at the nostrils or mouth at the time of the x-ray.
- How the tube placement was interpreted.
- Clear instructions as to any required actions.
- If the x-ray has been formally reported upon, a clinician must write in the healthcare record that they have viewed the radiologists report and that the feeding tube position is confirmed as satisfactory.

Any healthcare professional that relies on x-ray confirmation of the tube's position should confirm before feeding that:

- The entry in the patient's notes is the most recent one.
- The tube has not become dislodged by cross-checking the measurement of the tube at the nostril or mouth with the entry confirming correct tube placement.

Any tube identified by x-ray as being in the <u>incorrect</u> position must be removed immediately and documented in the medical notes.

If applicable, the guidewire may be removed prior to position check. It is not required for x-ray purposes.

NEVER RE-INSERT THE GUIDEWIRE WHILE THE TUBE IS POSITIONED IN THE PATIENT AS THE WIRE COULD PERFORATE THE TUBE AND DAMAGE ADJACENT ORGANS.

Section 6 - Securing the tube once placement is confirmed.

- Ensure patient is not allergic to the fixation tapes.
- It is routine in neonatal and paediatric care to place Duoderm on the cheek or chin **under** the tube as to protect the skin from the tube and to prevent pressure areas.
- Secure the tube to the cheek or chin with suitable fixation tape in a manner that avoids friction with the nostril or lip, and keeps it out of the patient's field of vision (nasogastric).
- In small infants and children, it is important the tube is sufficiently secured with tape to prevent the patient from removing the tube either by accident or intentionally.
- In older children and in those unlikely to remove their own tube, the tape should allow for a 'bridge' between the tube and the skin to reduce skin traction.
- It is suitable to use Tegaderm IV dressings (cut to appropriate size) and Mefix adhesive tape to secure the tube.

Section 7 – Documentation.

At the end of nasogastric tube insertion, document the following in the medical notes, using the Trust Nasogastric Tube Insertion Record label (**APPENDIX 1)**:

- Date and time of procedure.
- Correct patient identified and consented to procedure.
- Reason for enteral insertion.
- Size and make of tube inserted.
- NEX or MEX measurement and secured length of tube. Location of tube (including which nostril used if applicable).
- Correct procedure positioning and number of attempts to pass tube.
- Confirmation of tube position – pH value; or X-Ray confirmation if applicable.
- Name and registration number of practitioner undertaking procedure.
- Name and registration number of second practitioner to confirm correct pH.

Worcestershire Acute Hospitals NHS Trust

Appendices

Appendix 1 – NG tube insertion record

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:
Clininician name:
Clinician sign:
Clinician GMC:
Date: Time:
Safe to start feeding? Yes No
Begin regular position checks as per Policy

Re-order code: Xerox073

Monitoring

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?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.

References

Cannaby A, Evans L, Freeman A. (2002) *Nursing care of patients with nasogastric feeding tubes.* British Journal of Nursing Vol 11, No 6

National Institute for Health and Care Excellence (2017) *Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition* [NICE Guideline no. 32]. [Online]. National Institute for Health and Care Excellence. [Accessed 29/06/2021] Available at: *https://www.nice.org.uk/guidance/cg32/chapter/1-Guidance#enteral-tube-feeding-in-hospital-and-the-community*

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NPSA (2012) Rapid Response report: *Harm from flushing of nasogastric tubes before confirmation of placement.* National Patient Safety Agency, London

Worcestershire Acute Hospitals NHS Trust. *Neonatal and Paediatric Nasogastric Tube Insertion Competency Framework.* **Awaiting publication**

Worcestershire Acute Hospitals NHS Trust. *Neonatal and Paediatric Guidelines for Safe Use of Enteral Tubes.* **Awaiting publication**

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Great Ormond Street Hospital for Children NHS Foundation Trust (2012) *Management of feeding tubes policy.* [1.1]. London. Great Ormond Street Hospital for Children NHS Foundation Trust

Guidelines and Audit Implementation Network (2015) *Guidelines for caring for an infant, child or young person who requires enteral feeding.* [Online] Belfast. Guidelines and Audit Implementation Network. [Accessed 01.07.2021]. Available from: *4f08bb34-7955-49ea-adf1-9de807d3da66.pdf (rqia.org.uk)*

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Contribution List

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Alison Smith, Pharmacist
Louise Williams, Lead Pharmacist, Women & Children's Directorate

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Paediatric Quality Improvement
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.

Please complete assessment form on next page;

NHS
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		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:**			
What is the aim, purpose and/or intended outcomes of this Activity?				
Who will be affected by the development & implementation of this activity?	❑ ❑ ❑ ❑	Service User Patient Carers Visitors	❑ ❑ ❑ ❑	Staff Communities Other _____

Is this:	❑ 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				
Disability				
Gender Reassignment				
Marriage & Civil Partnerships				
Pregnancy & Maternity				
Race including Traveling Communities				
Religion & Belief				
Sex				
Sexual				

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Orientation				
Other Vulnerable and Disadvantaged Groups (e.g. carers; 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)				

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
		.		
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	
2.	Does the implementation of this document require additional revenue	
3.	Does the implementation of this document require additional manpower	
4.	Does the implementation of this document release any manpower costs through a change in practice	
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	
	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.