## Insertion and Confirmation of Position of Nasogastric Tubes for Adults and Children

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<th><strong>Reference Number:</strong></th>
<th>NHSCT/10/296</th>
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<td><strong>Target audience:</strong></td>
<td>Nursing and Medical Staff</td>
</tr>
</tbody>
</table>
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| **Date Approved:** | 18 March 2010 |
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**NHSCT Mission Statement**

To provide for all the quality of services we would expect for our families and ourselves
INSERTION AND CONFIRMATION OF POSITION OF NASOGASTRIC TUBES FOR ADULTS AND CHILDREN

MARCH 2010
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1. RATIONALE

This policy provides guidance for all nursing and medical staff in the Northern Health & Social Care Trust (NHSCT) on the safe insertion and confirmation of position of nasogastric (NG) tubes (4 – 18 Fr) being used for the purpose of feeding, drug administration or gastric aspiration. We recognise the contribution of dietetic colleagues in the ongoing care and management of NG tubes.

This policy applies to confirmation of NG tube position in adults, children and infants. Neonates are excluded from the scope of this policy. This policy also applies to insertion of NG tube in adults, children and infants (carers are excluded from insertion of NG tube in children and infants). Decisions regarding delegation to non-registrants and carers must be taken in line with the appropriate professional delegation framework (see Appendices 3 and 4).

The policy has been written taking into account National Patient Safety Agency’s Alert (NPSA) (February 2005), ‘Reducing the harm caused by misplaced feeding tubes’ which highlights the small risk that tubes can be misplaced into the lungs during insertion or may partially move out of the stomach at a later stage, increasing the risk of aspiration. It states the frequency and methods of confirmation.

* Non registrants, parents and carers refers to:
  - Trust Nursing Auxiliaries / Care Assistants / Support Carers.
  - Direct Payments Carers.
  - Crossroads / Barnardos Carers.
  This list is not exhaustive.

2. INTRODUCTION

2.1 NG tubes may be placed for feeding:

- In patients, children / young people who are unable to take/absorb adequate amounts of food and fluids to meet their requirements, or

- In patients, children / young people who have neurological deficits which mean they are unable to swallow safely and hence are recommended to be nil by mouth.

It is recommended that only fine bore (6-8 Fr) enteral feeding tubes with regular centimeter markings are used. These tubes can be used for up to 6 weeks as they are made from polyurethane or silicone, which are unaffected by gastric acid.
2.2 NG tubes may also be placed for aspiration of stomach contents. Ryles, Portex or Salem Sump PVC tubes should be limited to aspiration of gastric contents as they irritate the nose and oesophagus. These tubes need replaced after 2 weeks as they may be affected by gastric acid.

2.3 Medical advice should be sought for patients on anti-coagulant medication or varices.

3. **LINKED POLICIES**

- Hand Hygiene Policy  NHSCT/09/146.


4. **RECOMMENDATIONS FOR PRACTICE**

A patient, child / young person requiring NG tube insertion should be managed and supported by appropriately trained staff who have been assessed as competent in the procedure and who are practicing within the scope of the role. This includes Registered Nurses Acute and Community, Adults and Childrens Learning Disability branches, Registered Midwives and Specialist Community Public Health Nurses or Student Nurses under supervision and Registered Medical staff. Skills and competencies should be reviewed regularly and updated to reflect new practice in the management of an NG tube. Training must also extend to all staff (registered, non-registrants and carers) involved in care delivery within the wider social care setting, emphasising interagency and cross-boundary working in the care of children with complex needs.

4.1 Appropriately trained nurses, non-registrants and carers must be able to:

- Confirm the correct position of the NG tube.
- Know what action to take if aspirate is unobtainable.
- Know what action to take if the pH is greater than 5.5.
- Administer feeds via an NG tube.
- Unblock an NG feeding tube.
- Undertake mouth / nasal care in patient, child / young person with NG tube.

4.2 Ethical considerations as to the suitability of the patient, child / young person for an NG tube should be discussed and agreed within the multidisciplinary team. A detailed explanation of the procedure (need and process) should be discussed with the patient / relative / carer and consent sought and documented prior to insertion (Refer to Consent Policy).
For children / young people discussions will involve the parents / guardians as staff prepare them for care in the wider social care setting, emphasising the preparation of the child and, for example, the distraction techniques that may be needed. Such discussions may not be possible in certain areas eg. theatres / ICU.

4.3 Only two attempts should be made by any one person to insert a nasogastric tube. If the attempts are unsuccessful another more experienced practitioner should retry.

4.4 The following patients / child / young person may require referral to a specialist team ie. ENT, radiography, endoscopy for consideration of their suitability of nasogastric tube insertion:
- Children with neuro-disabilities / complex health needs.
- Unstable cervical spine.
- Basal skull fractures.
- Maxillo - facial disorders, surgery or trauma.
- Oesophageal tumours or surgery.
- Laryngectomy.
- Patients who have had oro-pharyngeal tumours or oro-pharyngeal surgery.
- Nasal CPAP.
- Do not insert a nasogastric tube in an unconscious patient who has sustained a head injury (particularly anterior or basal skull injury) - oro-gastric placement is the route of choice unless cranial fracture has been excluded.

5. INSERTION OF A NASOGASTRIC TUBE

The NHSCT will ensure that:
- Health professional staff and parents are trained and competency assessed in the placement of an NG tube and confirmation of the NG tube position. Non-registrants are trained and assessed to as competent in the confirmation of the NG tube position.
- pH indicator testing strips are stocked in all relevant care settings and are made available to carers and patients in the community.

Necessary equipment:
- Receiver.
- Fine bore nasogastric tube.
- 50ml enteral syringe and 20ml enteral syringe.
- Hypoallergenic tape.
- Glass of water (if the patient is able to swallow) and is allowed fluids.
- pH indicator strips (0.5 graduations).
- Personal Protective Equipment (PPE) - disposable gloves and apron.
- Indelible marking pen.
# PASSAGE OF NASOGASTRIC TUBE

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
<th>EVIDENCE</th>
</tr>
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<tbody>
<tr>
<td>5.1 Give a detailed explanation and obtain verbal consent.</td>
<td>To obtain the person's consent and co-operation.</td>
<td>CREST 2004, Pritchard et al 2004.</td>
</tr>
<tr>
<td>5.2 Ensure that the patient / child / young person knows a signal (eg. to raise hand) to communicate that he / she wants the nurse to stop.</td>
<td>The person is often less frightened if he / she feels able to have some control over the procedure.</td>
<td>Mensforth, A &amp; Nightingale, JMD (2001). Mallet, J &amp; Dougherty, L (2000).</td>
</tr>
<tr>
<td>5.3 Help the patient / child / young person to sit in a supported, comfortable upright position (55-65° angle) in the bed or chair supported by pillows. NB The head should not be tilted backwards. If unconscious, place in a safe position by laying the patient on their side, do not extend the neck.</td>
<td>To allow for easy passage of the tube. This position enables easy swallowing and ensures the epiglottis is not obstructing the oesophagus. To ensure correct passage and position of the tube.</td>
<td>McConnell, EA (1997). Mallet, J &amp; Dougherty, L (2000).</td>
</tr>
<tr>
<td>5.4 Ensure strict hand hygiene is adhered to and PPE put on prior to commencing procedure.</td>
<td>To minimise cross infection.</td>
<td></td>
</tr>
<tr>
<td>5.5 Standard Infection Control precautions should be used when performing this procedure.</td>
<td>To minimise cross infection.</td>
<td>Regional Infection Prevention Control Manual</td>
</tr>
<tr>
<td>5.6 Determine the length of tube required by measuring from the nose to the ear lobe and then to the xiphisternum and mark this length on the tube (limiting mark) with pen or tape. In children the centimetre marking should be noted. Where a guidewire is present, straighten the tube by stretching, this makes it easier to remove the guidewire afterwards. If present, ensure guidewire is fully locked on to the end of the NG tube. Lubricate the end of the tube with water - do not use lubricating gel as it gives an acid reaction (CREST, 2004).</td>
<td>To ensure that the appropriate length of the tube is passed into the stomach.</td>
<td>Mallet, J &amp; Dougherty, L (2000).</td>
</tr>
</tbody>
</table>
5.7 If patient / child / young person has intact swallow reflex - ensure a glass of water or bottle is available to sip in preparation for tube placement.

If patient / child / young person is ‘Nil by mouth’ - they should be asked to repeatedly carry out a swallow action, but not take a drink.

A young child may be given a comforter ‘dummy’ as appropriate.

5.8 Ask the patient / child / young person to blow their nose if they are able to clear the nasal passages.

Check nostrils are patent by asking the patient / child / young person to sniff with one nostril closed. Repeat with other nostril.

Insert the rounded end of the tube into the nostril, slide it backwards and inwards along the floor of the nose to the nasopharynx.

Withdraw if any obstruction is felt, try again at a slightly different angle or use the other nostril.

5.9 As the tube passes into the nasopharynx ask the patient / child / young person to start swallowing (or sip water if able).

A swallowing action closes the glottis enabling the tube to pass into the oesophagus.

<p>| 5.7 | If patient / child / young person has intact swallow reflex - ensure a glass of water or bottle is available to sip in preparation for tube placement. If patient / child / young person is ‘Nil by mouth’ - they should be asked to repeatedly carry out a swallow action, but not take a drink. A young child may be given a comforter ‘dummy’ as appropriate. Dummy provides comfort and stimulates the sucking reflex which can aid the passing of the tube. |  |
| 5.8 | Ask the patient / child / young person to blow their nose if they are able to clear the nasal passages. Check nostrils are patent by asking the patient / child / young person to sniff with one nostril closed. Repeat with other nostril. Insert the rounded end of the tube into the nostril, slide it backwards and inwards along the floor of the nose to the nasopharynx. Withdraw if any obstruction is felt, try again at a slightly different angle or use the other nostril. To facilitate the passage of the tube following the natural anatomy of the nose. To avoid trauma to the nasal passage. | Pritchard et al (2004). Mensforth, A &amp; Nightingale, JMD (2001). Mallet, J &amp; Dougherty, L (2000). |
| 5.9 | As the tube passes into the nasopharynx ask the patient / child / young person to start swallowing (or sip water if able). A swallowing action closes the glottis enabling the tube to pass into the oesophagus. | Mallet, J &amp; Dougherty, L (2000). |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>5.10</td>
<td>Advance the tube until you reach the point where the tube was measured and marked. As the tube insertion proceeds observe the patient / child / young person and remove the tube if coughing, distress or cyanosis occurs. Withdraw tube as this may indicate tracheal placement. <strong>NB Maximum of 2 attempts.</strong> Check inside the mouth for a coil of tube if the patient is unable to communicate.</td>
</tr>
<tr>
<td>5.11</td>
<td>Confirm correct placement of tube before removing guide wire by aspirating tube using 50ml enteral syringe <em>(SEE SECTION 6 BELOW)</em>.</td>
</tr>
<tr>
<td>5.12</td>
<td>Care should be taken to ensure that the end of the tube is firmly closed with a spigot when not in use and that this is checked regularly. To ensure that acidic gastric contents do not leak or siphon from the tube, resulting in caustic burns to the patient's skin.</td>
</tr>
<tr>
<td>5.13</td>
<td>Measure the length of tubing remaining from the nostril to the tip (ie. visible tubing). In paediatrics, the centimetre (cm) marking at the exit of the nostril must be recorded, where cm markers are clearly visible <em>(Appendix 1B)</em>. Record using form in Appendix 1A of policy. Give baseline against which to assess possible tube displacement.</td>
</tr>
<tr>
<td>5.14</td>
<td>Once the position has been confirmed <em>(see section 6)</em> remove the guidewire. To remove the guidewire attach a 20ml enteral syringe containing 10ml of water to the end of the tube and slowly inject the water down the tube. This activates the internal lubricant in the tube and aids removal. The tube should be held firmly at the tip of the nose to ensure that the tube stays in position as the guidewire is removed. The guidewire may now be removed carefully. <strong>The guidewire must never be reinserted while the tube is still in the patient</strong> <em>(CREST, 2004)</em>.</td>
</tr>
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</table>

Some patients do not have a cough reflex and unrecognised entry to the trachea may occur eg. in Stroke, Neuro sedated and Trauma patients. Mallet, J & Dougherty, L (2000).
In the community setting when a tube is accidentally removed by child / young person, reinsertion of the guidewire to facilitate replacement of the NG tube may be appropriate and must be covered by development of a Standard Operating Procedure.

5.15 Following successful insertion use an adhesive patch to anchor the tube securely to the cheek and hook it over the ear, keeping it out of the patient’s visual fields and avoiding friction to the nose.

Where the adhesive patch proves unsuitable, use a barrier product such as a hydrocolloid dressing to protect the skin and a transparent dressing placed over this to hold the tube in place.

Consider use of nasal bridle to secure the NG tube if NG is frequently displaced (NICE Clinical Guidelines (32) 2006).

To maintain the tube in place.
To ensure comfort.

5.16 Remove PPE and decontaminate hands following NG tube insertion.

5.17 At all times during the procedure talk to and reassure the patient / child / young person.

5.18 Document the procedure, size and type of tube and method used to confirm the position of the tube in the patient’s medical and nursing notes, if the patient is in hospital. If the client is at home, record the above information in the Community Nursing notes kept in the client’s own home in addition to:

- Signature of staff / parent passing the tube, including date and time of placement (see Appendices 1A and 1B).
<p>| | |</p>
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<tbody>
<tr>
<td>• Measurement of the external tube length / external marking at exit of nostril in children.</td>
<td></td>
</tr>
<tr>
<td>• pH of each aspirate obtained.</td>
<td></td>
</tr>
<tr>
<td>• Action taken if aspirate above pH 5.5 or if aspirate unobtainable (refer to page 12).</td>
<td></td>
</tr>
<tr>
<td>• Tube displacement</td>
<td></td>
</tr>
<tr>
<td>• Accurate fluid balance / diet record sheet.</td>
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</table>

This information should be recorded each time a tube is passed.

5.19 Flush the tube with sterile water or flushes as per feeding regimen before commencing feeding.

6. **CONFIRMATION OF NASOGASTRIC TUBE POSITION**

The NPSA alert (February 2005) highlighted that conventional methods used to check placement of nasogastric tubes are inaccurate on their own and can increase the risk of a misplaced tube being used for feeding.

Therefore:

- Auscultation of air insufflated through the feeding tube (“whoosh test”) is unreliable and should **not** be used at any time.

- Testing of aspirate with blue Litmus paper is **not** recommended. Blue Litmus paper is not sensitive enough to distinguish between bronchial and gastric secretions.

- Do **not** rely on monitoring bubbling at the end of the tube. Observing for bubbling at the proximal end of the tube is unreliable because the stomach also contains air and could **falsely** indicate respiratory placement.

- Do **not** rely only on observing the appearance of the tube aspirate - gastric and respiratory secretions can look similar.

- Do **not** interpret the absence of respiratory distress as an indicator of correct position of tube. Fine bore tubes can enter the respiratory tract with few / no symptoms.
Radiography is the most accurate method for testing tube position. Where a patient has a significantly altered level of consciousness eg. theatres / ICU the standard method of confirmation of nasogastric tube position will be by examination of an x-ray.

In any other area, the use of radiology to confirm nasogastric tube position will not be routine but when gastric secretion pH and visual methods continue to produce uncertainty, then tube position should be confirmed by x-ray. The use of x-ray can lead to delays in feeding, is inconvenient for the patient, causes unnecessary exposure to radiation and is costly. For these reasons, chest x-ray should not be used routinely (NPSA, February 2005).

Due to the frequency with which the position of NG tubes must be checked the use of pH measurement and visual observation techniques as described in the NPSA safety alert are essential.

The attached flowcharts recommend the most suitable procedure to follow (refer to flowcharts at Appendix 2a Adults and 2b Infants and Children).

**Equipment required for confirmation of position / check aspirate:**

- Disposable gloves and apron.
- 50ml enteral syringe.
- ph testing strips in 0.5 graduations.
- Disposable tray.
All misplacement incidents should be reported by completing a Clinical Incident Report Form.

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
<th>EVIDENCE</th>
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<tbody>
<tr>
<td><strong>INITIAL PLACEMENT.</strong></td>
<td></td>
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</tr>
<tr>
<td>6.1</td>
<td>Decontaminate hands and put on gloves and apron.</td>
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<tr>
<td></td>
<td>Insert the 50ml enteral syringe into the medicine port on the nasogastric tube and carefully pull back the plunger, ensuring the position of the tube is maintained.</td>
<td></td>
</tr>
<tr>
<td><strong>Testing of aspirate</strong></td>
<td></td>
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<tr>
<td>6.2</td>
<td>In adults before aspirating - flush the tube with 20ml of air to clear any debris / substances.</td>
<td>Acts in moving the tube away from the stomach wall and removing debris to aid aspiration.</td>
</tr>
<tr>
<td></td>
<td>In children, under supervision, open the end of the tube to allow any vacuum to be released prior to testing.</td>
<td>Mallet, J &amp; Dougherty, L (2000). Canaby, A; Evans, L &amp; Freeman, A (2002).</td>
</tr>
<tr>
<td></td>
<td>Aspirate 2mls from the tube (using a 50ml enteral syringe) and test on pH indicator strips with 0.5 graduations.</td>
<td>Stomach contents are acidic and have a pH between 1 and 5.5.</td>
</tr>
<tr>
<td><strong>pH 1 – 5.5 FEED</strong></td>
<td></td>
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<tr>
<td>6.3</td>
<td>Using the colour guide on the pH strip packaging, determine the pH. An aspirate with a pH 5.5 or less indicates continued placement of the tube in the stomach.</td>
<td></td>
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<tr>
<td></td>
<td>Document the pH in the patient’s notes (Appendices 1A and 1B). Note: the pH should be recorded in the patient’s notes EVERY time the aspirate is checked.</td>
<td></td>
</tr>
</tbody>
</table>
### 6.4 pH 5.5 - 6 DO NOT FEED

- Check with another competent adult if the reading is accurate.
- If not on acid inhibiting medication withdraw tube slightly and reaspire.
- If aspirate remains 5.5-6.0, consider chest X-ray.
- If on acid inhibiting medication, retry aspirating as long after giving medication as is practical.
- It may take several attempts to obtain an aspirate below 5.5. Leave 1 hour between attempts.
- If still unable to get aspirate, consider chest x-ray.

### 6.5 pH 6 - 8 DO NOT FEED

The most likely reason for failure to obtain gastric aspirate below pH 5.5 is the dilution of gastric acid by enteral feed. Waiting for up to 1 hour after feeding has ended will allow time for the stomach to empty and the pH to fall (NPSA 2005).

- In adults, pull tube out by 10cm and reaspire, if still above 6 remove and reinsert.

- In children, withdraw tube slightly and reaspire.

### 6.6 IF NO ASPIRATE OBTAINED:

It may take several attempts to obtain an aspirate and it may be necessary to wait 1 hour between attempts.

### 6.7 In adults, advance or withdraw tube 10 - 20cm and aspirate with 20ml syringe.

---

Proton Pump Inhibitors (Omeprazole, Lansoprazole), H2 Antagonists (Ranitidine, Cimetidine) Antacids (eg. Maalox, Gaviscon) temporarily reduce gastric acidity and hence increase the pH by neutralising hydrochloric acid.

A pH of 6-8 may indicate small bowel passage. Aspirate may be bile and coloured green/yellow. A pH of 6 may also suggest bronchial placement.

Tube may be occluded in stomach mucosal wall or blocked with debris.
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<tbody>
<tr>
<td><strong>6.8</strong></td>
<td>In adults, inject 20mls air with 20 - 50ml syringe several times.</td>
<td>Nasogastric tube may be above the gastric juice level in the stomach.</td>
</tr>
<tr>
<td><strong>6.9</strong></td>
<td>If patient sitting up, turn patient onto their left side, inject 20ml of air and retry aspiration with 20ml syringe</td>
<td>If patient belches immediately, tube may be in oesophagus. Therefore advance further or re-pass.</td>
</tr>
<tr>
<td><strong>6.10</strong></td>
<td>Try syphon affect by putting syringe below the level of the stomach and retry aspiration.</td>
<td>Gravity may help to obtain the aspirate.</td>
</tr>
<tr>
<td><strong>6.11</strong></td>
<td>In children / young people, turn infant / child on to side. Inject 1 – 5mls air into tube using 20ml or 50ml syringe. Wait for 15 – 30 minutes. Advance tube by 1 – 2cm and retry aspiration. Open the end of the tube under supervision as described in 6.2.</td>
<td><strong>DO NOT FEED</strong> Discuss with medical staff whether to repass tube or obtain chest x-ray to confirm position.</td>
</tr>
</tbody>
</table>

**WHEN ASPIRATE IS OBTAINED:**

The pH of the aspirate confirming correct tube position must recorded in the Nasogastric Tube Positioning Record Sheet (see Appendices 1A and 1B).**

NPSA (2005).
7. **WHEN TO CONFIRM THE GASTRIC POSITIONING OF THE NASOGASTRIC TUBE**

- On initial placement.
- Before administration of feed / water following a rest period or before bolus feeding.
- Before administration of medications if the tube is only used for medications.
- If the patient complains of discomfort.
- After an episode of coughing, sneezing, vomiting or retching.
- After oropharyngeal suctioning.
- If the visible part of the tube appears to have changed in length or the tape securing the tube becomes loose.
- At least once daily during continuous feeding.
- If the patient becomes acutely distressed, breathless or has difficulty breathing during or after the administration of enteral feed, medicines or flushing.
- If the patient is transferred from one clinical area to another, the receiving clinical area must confirm tube position before commencing feed.
- If there is any doubt about the position of the tube.

8. **REFERENCES**


CREST, Guidelines for the management of enteral tube feeding in adults, CREST. Belfast.


NPSA, Reducing the harm caused by misplaced nasogastric feeding tubes, February 2005.


9. **BIBLIOGRAPHY**


Regional Infection Prevention Control Manual [www.infectioncontrolmanual.co.ni](http://www.infectioncontrolmanual.co.ni)

NASOGASTRIC TUBE POSITION RECORD SHEET (ADULT)

<table>
<thead>
<tr>
<th>Patient Details. (Attach Patient ID Label)</th>
<th>Feeding tube- on insertion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>Type and size of NG tube</td>
</tr>
<tr>
<td>Hospital number</td>
<td>Date of insertion / reinsertion</td>
</tr>
<tr>
<td>Name</td>
<td>External length of tube(cm)</td>
</tr>
<tr>
<td>Address</td>
<td>pH on insertion _____________</td>
</tr>
<tr>
<td></td>
<td>X-ray required on initial insertion  Y/N</td>
</tr>
</tbody>
</table>

- Gastric aspirate MUST be checked using pH paper with 0.5 graduations.
- Aspirate MUST be pH 5.5 or less to confirm placement in the stomach.
- Tube position MUST be checked BEFORE administering feed, medications or flushing and after episodes of sneezing, retching vomiting or coughing OR if there is any doubt of the tube position.

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>If aspirate obtained, pH reading</th>
<th>If no aspirate obtained, action taken</th>
<th>If pH &gt; 5.5, action taken</th>
<th>External length of tube (cm)</th>
<th>Any coughing / retching / vomiting?</th>
<th>Gastric position confirmed?</th>
<th>Signature</th>
</tr>
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</table>
### NASOGASTRIC TUBE POSITION RECORD SHEET (CHILDREN)

<table>
<thead>
<tr>
<th>Patient Details. (Attach Patient ID Label)</th>
<th>Feeding tube- on insertion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>Type and size of NG tube</td>
</tr>
<tr>
<td>Hospital number</td>
<td>Date of insertion / reinsertion</td>
</tr>
<tr>
<td>Name</td>
<td>External marking at exit of nostril (cm)</td>
</tr>
<tr>
<td>Address</td>
<td>pH on insertion _____________</td>
</tr>
<tr>
<td></td>
<td>X-ray required on initial insertion Y/N</td>
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- Gastric aspirate **MUST** be checked using pH paper with 0.5 graduations.
- Aspirate **MUST** be pH 5.5 or less to confirm placement in the stomach.
- Tube position **MUST** be checked **BEFORE** administering feed, medications or flushing and after episodes of sneezing, retching vomiting or coughing **OR** if there is any doubt of the tube position.

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>If aspirate obtained, pH reading</th>
<th>If no aspirate obtained, action taken</th>
<th>If pH &gt; 5.5, action taken</th>
<th>External marking at exit of nostril (cm)</th>
<th>Any coughing / retching / vomiting?</th>
<th>Gastric position confirmed?</th>
<th>Signature</th>
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CONFIRMING THE CORRECT POSITION OF NASOGASTRIC FEEDING TUBES IN ADULTS

1. Check if on acid inhibiting medication
2. Check for signs of tube displacement and measure tube length
3. Reposition or repass tube if required
4. Aspirate using 50ml syringe and gentle suction

Aspirate not obtained

DO NOT FEED
1. If possible, turn adult onto side
2. Inject 10 – 20ml air into the tube using syringe
3. Wait for 15 – 30 minutes
4. Try aspirating again

Aspirate not obtained

DO NOT FEED
1. Advance tube by 10 – 20cm
2. Try aspirating again

Aspirate obtained (0.5 – 1ml)

Test on pH strip or paper

Aspirate obtained (0.5 – 1ml)

pH 6 or above

DO NOT FEED
1. Leave for up to one hour
2. Try aspirating again

pH 5.5 or below

pH 6 or above

DO NOT FEED
1. Call for advice
2. Consider replacement / repassing of tube and/or checking position by x-ray

pH 5.5 or below

Proceed to feed

CAUTION: If there is ANY query about position and / or the clarity of the colour change on the pH strip, particularly between ranges 5 and 6, then feeding should NOT commence

NPSA FEBRUARY 2005
CAUTION: If there is ANY query about position and/or the clarity of the colour change on the pH strip, particularly between ranges 5 and 6, then feeding should NOT commence.
The delegation of nursing or midwifery care must be appropriate, safe and in the best interests of the person in the care of a nurse or midwife.

Prior to agreeing to delegation, the nurse or midwife has the responsibility to understand this advice.

Failure to follow the provision of this advice may bring the nurse or midwife’s fitness to practise into question. However, the decision to delegate would be judged against what could be reasonably expected from someone with their knowledge, skills and abilities when placed in those particular circumstances.

The Code : Standards for Conduct, Performance and Ethics for Nurses and Midwives, states:

- You must establish that anyone you delegate to is able to carry out your instructions.
- You must confirm that the outcome of any delegated task meets the required standards.
- You must make sure that everyone you are responsible for is supervised and supported.

This advice provides a set of principles for nurses and midwives when delegating to others. (This may also include delegation to carers and relatives, but in general terms the employer would not have vicarious responsibility for non-employees).

The principles in this advice should be adhered to with clear lines of accountability and responsibility identified and agreed.

The nurse or midwife, when delegating, is authorising that person to perform aspects of care normally within the nurse / midwife’s scope of practice.

(This standard does not refer to the delegation of an aspect of care to a student. Nurses and midwives should refer to the NMC’s Standards to Support Learning and Assessment in Practice; NMC Standards for Mentors, Practice Teachers and Teachers 08.06 and to Section 5 on Delegation in the NMC’s Standards for Medicines Management 2008).
Principles

The delegation of nursing or midwifery care must always take place in the best interests of the person the nurse or midwife is caring for and the decision to delegate must always be based on an assessment of their individual needs.

Midwives should not delegate their statutory midwifery duties eg. attending women in childbirth – see NMC Circular 1/2004.

Where a nurse or midwife has authority to delegate tasks to another, they will retain responsibility and accountability for that delegation.

A nurse or midwife may only delegate an aspect of care to a person whom they deem competent to perform the task and they should assure themselves that the person to whom they have delegated fully understands the nature of the delegated task and what is required of them.

Where another, such as an employer, has the authority to delegate an aspect of care, the employer becomes accountable for that delegation. The nurse or midwife will however continue to carry responsibility to intervene if she feels that the proposed delegation is inappropriate or unsafe.

The decision whether or not to delegate an aspect of care and to transfer and / or to rescind delegation is the sole responsibility of the nurse or midwife and is based on their professional judgement.

The nurse of midwife has the right to refuse to delegate if they believe that it would be unsafe to do so or if they are unable to provide or ensure adequate supervision.

Those delegating care, and those employees undertaking delegated duties, should do so in accordance with robust local employment practice, to protect the public and support safe practice.

The decision to delegate is either made by the nurse or midwife or the employer and it is the decision maker who is accountable for it.

Healthcare can sometimes be unpredictable. It is important that the person, to whom an aspect of care is being delegated, understands their limitations and when not to proceed should the circumstances within which the task has been delegated change.

No one should feel pressurised into either delegating or accepting a delegated task. In such circumstances advice should be sought, in the first instance, from the nurse or midwife’s professional line manager and then, if necessary, the NMC.
Accountability

A nurse or midwife who delegates aspects of care to others remains accountable for the appropriateness of that delegation and for providing the appropriate level of supervision in order to ensure competence to carry out the delegated task.

The nurse or midwife remains accountable for the delivery of the care plan and for ensuring that the overall objectives for that patient are achieved.

Responsibility

An aspect of care may be delegated to a person who the nurse or midwife judges as having the competence to undertake it. If the person to whom the task is delegated is in employment, it is the employer’s responsibility to ensure that they have sufficient education and training to competently undertake the aspects of care which a nurse or midwife is expected to delegate to them.

If, in any particular case, either the nurse or midwife, or the person to whom the nurse or midwife might delegate an aspect of care, does not think that the latter is competent to undertake the task, then they should not delegate it.

Having delegated an aspect of care the person to whom it is delegated will be responsible to their line manager for the performance of the task.

The nurse or midwife delegating an aspect of care has a continuing responsibility to judge the appropriateness of the delegation by:

- Reassessing the condition of the person in the care of the nurse or midwife at appropriate intervals and determining that it remains stable and predictable; and

- Observing the competence of the caregiver(s) and determining that they remain competent to safely perform the delegated task of care safely and effectively.

- Evaluating whether or not to continue delegation of the task.

Documentation

The assessment, planning and evaluation of the person’s care must be documented. The nurse or midwife has a responsibility also to ensure that any aspect of care delegated has been documented appropriately.

‘Registrants are required to use their professional judgement to decide what is relevant and what should be recorded’ – NMC Record Keeping Advice Sheet (07/07).
Before delegation occurs the nurse or midwife must have considered the following:

- The condition of the person in their care.
- The competence of the recipient(s) of the delegation; there should be records to support and evidence this.
- How frequently the person in their care should be reassessed in relation to the continued delegation of the aspect of care.
- The ongoing support arrangements that will be provided to those undertaking delegated duties.

Documentation should clearly outline any decision making processes and must be person specific. The most appropriate place to record this information should be decided based on the working environment ie. patient held records / care plans. At each delegation the names of those being delegated to must be clearly stated.

Nurses and midwives are accountable for ensuring continued assessment of the competence of those they are delegating to.

**Glossary**

**Competence** – a bringing together of general attributes – knowledge, skills and attitudes. Skill without knowledge, understanding and the appropriate attitude does not equate with competent practice. Thus, competence is ‘the skills and ability to practise safely and effectively without the need for direct supervision’ (UKCC 1999; Watson 2002).

**Delegation** – the transfer to a competent individual, the authority to perform a specific task in a specified situation that can be carried out in the absence of that nurse or midwife and without direct supervision.

**People / Person** – the terms people / person has been used to represent all recipients of care, including children and young people and those in acute and community settings.

**Other** – a group of care providers that are neither registered or licensed by a regulatory body and have no legally defined scope of practice. Includes titles such as Healthcare Support Workers, Associate Practitioners, Assistant Practitioners and Nursing Assistants. It also refers to support staff regulated by one of the other UK regulators and not necessarily the NMC eg. support staff working in residential homes who may be registered with the General Social Care Council.
Accountability – the principle that individuals, organisations and the community are responsible for their actions and may be required to explain them to others.

Responsibility – a form of trustworthiness; the trait of being answerable to someone for something or being responsible for one’s conduct.

Fitness to Practise – fitness is a nurse of midwives suitability to be on the register without restrictions. The NMC deals with allegations that a nurse or midwife’s fitness to practise is impaired.

Further Information

- NMC Advice Sheet on Accountability.
CENTRAL NURSING ADVISORY COMMITTEE
OPERATIONAL FRAMEWORK FOR
DELEGATION DECISION MAKING

In delegating, the nurse or midwife must ensure the appropriate assessment, planning, implementation and evaluation of the person’s care. The process is continuous and based on the following:-

1. **The right task**
   Delegation of care occurs following a written assessment of the individual person’s needs and is supported by organisational policies and procedures.

2. **The right circumstances**
   The specific circumstances in which care may, or may not be delegated are considered, taking account of the setting and availability of adequate resources.

3. **The right person**
   Systems are in place to ensure the competency of the care giver is established and maintained and to provide ongoing monitoring and support. This will include knowing when to seek appropriate advice.

4. **The right communication**
   The plan of care will include clear, concise description of the task, including expected and actual outcomes. Records are maintained of all aspects of the delegation process.

5. **The right feedback.**
   A process for ongoing monitoring and support is established to ensure the delivery of safe and effective care. This will include an evaluation of the outcomes and the patients’ experience.

This framework acknowledges the work undertaken by the National State Boards of America¹.

Has there been a nursing / midwifery assessment of the patient / client needs?

- NO: Do not delegate
- YES
  
Is the task to be delegated within the scope of practice and therefore authority of the nurse / midwife to delegate?

- NO: Do not delegate
- YES
  
Has the care giver been provided with education and training to undertake the task?

- NO: Do not delegate
- YES
  
Has the care giver been supervised and deemed competent to perform the task?

- NO: Do not delegate
- YES
  
Has an evaluation process been agreed to measure outcomes and reassess competency?

- NO: Do not delegate
- YES

Delegate the task