POLICY FOR NASOENTERIC (NASOGASTRIC AND NASOJEJUNAL) TUBE INSERTION AND MANAGEMENT FOR ADULTS
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<th>Policy Title:</th>
<th>Nasoenteral (nasogastric and nasojejunal) tube Insertion and Management for Adults</th>
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<tr>
<td>Executive Summary:</td>
<td>To optimise the nutritional care of adult in-patients under the care of East Cheshire NHS Trust.</td>
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<td>Supersedes:</td>
<td>Enteral Feeding Policy for Adults, version 1.3</td>
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<tr>
<td>Description of Amendment(s):</td>
<td>Policy updated for Patient Safety Alert: Nasogastric tube misplacement: continuing risk of death and severe harm. NHS/PSA/RE/2016/006</td>
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<td>This policy will impact on:</td>
<td>All staff caring for adult inpatients under the care of East Cheshire NHS Trust.</td>
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<td>Financial Implications:</td>
<td>Improvements in nutritional care should reduce costs and risks associated with sub-optimal patient nutrition.</td>
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<tr>
<td>Version Number:</td>
<td>Version 1.4</td>
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<tr>
<td>Effective Date:</td>
<td>September 2018</td>
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<td>Issued By:</td>
<td>Kath Senior Director of Nursing and Patient Care Standards</td>
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<td>Review Date:</td>
<td>July 2020</td>
</tr>
<tr>
<td>Author:</td>
<td>Maggie Allen Endoscopy Nurse Practitioner</td>
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<td>Impact Assessment Date:</td>
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<td>Management</td>
<td>April 2018</td>
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<td>Clinical Nutrition Steering Group</td>
<td>July 2018</td>
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<tr>
<td>Departments of Dietetics, Pharmacy and Gastroenterology, Matrons, Nursing and Midwifery forum</td>
<td>Version 1.4a sent to groups for comment in April 2018</td>
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<td>Approved by Director:</td>
<td>Kath Senior</td>
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<td>Received for information:</td>
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**AMMENDMENTS RECORD**

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<td>May 2012 – version 1.2</td>
<td>Policy updated for NPSA/2012/RRR001 alert compliance</td>
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<tr>
<td>August 2014 – version 1.3</td>
<td>Policy reviewed.</td>
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1.0 INTRODUCTION

A Nasoenteric tube can be inserted transnasally into the stomach or small bowel. It is commonly used for delivery of feed, fluids, medication, or drainage of gastric contents (NG only).

Nasogastric (NG), feeding into stomach, is the most common method of providing artificial nutritional support. It is generally the first route of choice in the acute setting as it is minimally invasive and can be inserted at the bedside. It is commonly used for short term feeding (4-6 weeks). This can be extended if feeding by an alternative route is inappropriate or not possible, i.e. gastrostomy tube.

Nasojejunal (NJ), feeding into the small bowel, is less common as and only used if gastric feeding is contraindicated. The tube can be placed under direct vision endoscopy, by bedside tube manipulation technique, or during abdominal surgery and is generally positioned so that the distal tip lies in the proximal jejunum distal to the ligament of trietz, although, depending on the indication, some tubes may be placed into the duodenum only.

This policy reflects the NPSA/NHS Improvement guidance for nasogastric tubes (2005- 2016).

‘Thousands of nasogastric feeding tubes are inserted daily without incident. However, there is a small risk that nasogastric feeding tubes can be misplaced in the lungs during insertion, or can migrate out of the stomach at a later stage. Feeding through a misplaced NG tube is a ‘never event’ as it causes serious harm and can result in death.’


The policy is to be used in conjunction with the following policies and guidelines: -

- Guidelines for Oral Nutrition Support in Adult Inpatients
- Policy for Administration of Feed and Fluid via Enteral Tubes for Adults
- Guidelines for Insertion and Management of Nasogastric Bridles
- Guidelines for Assessment and Monitoring of Patients Receiving Enteral Feeding
- Medication administration in patients with oropharyngeal dysphagia.

2.0 PURPOSE

- To promote a clear, consistent and evidenced based approach to the insertion, care and management of nasoenteric tubes.
- To promote the safety and well-being of all patients who require a nasoenteric tube.
To provide guidance regarding scope of professional practice, level of competence and accountability in nasoenteric tube insertion, care and management.

To provide a framework for roles and responsibilities in nasoenteric tube insertion and care thereafter.

3.0 RESPONSIBILITIES

This policy is aimed at all employees of East Cheshire NHS Trust (ECT) and staff of other organisations who are working within the Trust, who have direct responsibility for the placement and management of nasoenteric feeding tubes for adult patients. Specific professional and departmental responsibilities are as follows:

The Chief Executive has overall responsibility for ensuring that the trust has appropriate policies and robust monitoring arrangements in place.

The Director of Nursing, Performance & Quality, who is a member of the Trust Board, has overall responsibility for the provision of nutrition in the Trust. The Clinical Nutrition Steering Group (CNSG) is responsible for the oversight of all aspects of nutrition within the Trust and is accountable to the Trust Board via the Quality Forum (formerly the Quality Strategy Group.)

For further information regarding the role and responsibility of the CNSG in the provision of nutrition, refer to the East Cheshire NHS Trust CNSG 001 Nutrition Policy for in-patients.

All clinical service team managers are responsible for ensuring compliance with this policy within their unit/team and that staff are competent in the practice and attend appropriate training.

All Trust employees involved in the practice of enteral feeding are responsible for ensuring that they are competent in the procedures used and deliver practice to the policy standards.

Certain professional groups and departments have specific responsibilities:

Dietitians

- Assessment and monitoring the patient’s nutritional status.
- Advise on the appropriateness for enteral feeding.
- Advise on the appropriate route for enteral feeding.
- Advise on a suitable feeding regime to meet the patient’s nutritional requirements.
- Monitoring the progress of a patient on enteral feeding and advice of any necessary changes to a patient’s feeding regime.

Registered Nurse/Midwife (and other Healthcare Professionals, as appropriate)

- As part of a multi-disciplinary team, make the decision to insert tube following appropriate assessment and consultation with the patient /carer and other team members.
- Gain consent and provide patient information.
- Insert the tube and verify the tube position as per Trust policy.
- Assess patient comfort and safety through regular observation.
- Report any adverse events via Datix.
- Complete documentation regarding procedure and checking the position of the tube
- Initiate a nasogastric monitoring chart to be used whilst the tube is in situ.
- Liaise with other healthcare professionals regarding patient status and requirements
- Provide patients and carers with information about the care and management of the tube.
- As an individual or part of a multi-disciplinary team assess when to remove the tube.
• Perform procedure for removal and document outcome.
• For patients discharged with the tube *in situ*, ensure appropriate education, advice and competency of the patient / carer.
• The individual nurse or healthcare professional must be able to demonstrate evidence of
  - training in nasogastric tube management
  - competency assessment
  - up-to-date knowledge of nasogastric tube management.

**Ward Sister / Charge Nurse**

- Identify which members of staff are required to undertake various aspects of feeding and management of nasogastric feeding tubes.
- Ensure training and assessment of competence is undertaken and documented.
- Monitor standards of practice in their environment in relation to feeding and management of nasogastric feeding tubes.
- Weekly senior Sister documentation audits to include a section for NG tube compliance for any patients on the ward with an NG tube in place.

**Nasogastric tube champions** (nurses with greater level of expertise based on wards with higher percentage of nasogastric tube usage available to provide support for colleagues)

- Respond to colleagues requests for support and advice regarding nasogastric insertion and management
- Escalate potentially complex procedures to a specialist
- Assist with training and audit when required

**Matrons**

- Ensure training and assessment of competence is undertaken and documented in each clinical area.
- Monthly Matron documentation assurance audits to include a section on NG tube compliance for any patients on the ward with an NG tube in place.

**Speech and Language Therapists**

- Assessment of patient’s eating and drinking ability and any difficulties (dysphagia).
- Provision of advice on the appropriateness of enteral feeding with regards to dysphagia.
- Participation in multidisciplinary discussion (MDT) as to the appropriateness of enteral feeding with regard to clinical dysphagia assessment and clinical experience, to aid decision making for health care professionals and patients.
- Monitoring dysphagia while the patient is undergoing enteral feeding in order to advise the MDT with regard to reinstatement of oral feeding.
- Assessment and provision of advice on oral intake/tasters for all patients who are enterally fed long term.

**Pharmacy:**

- Provide a medicines information service for staff, patients and carers and advising on medicine administration for patients unable to take medicines orally.
- Advise on and monitoring the safe, effective and economic use of medicines.
- Monitor for medicine interactions/adverse reactions and whether the therapy is achieving the desired therapeutic effect.
Gastroenterology department:
- Review and assessment of patients with a complex medical history with high risk of complication relating to nasogastric tube insertion and management.
- Facilitate endoscopic insertion of NG/NJ tubes where appropriate.

Endoscopy Department:
- Store and maintaining stock levels of standard and specialist enteral feeding equipment, that comply with national standards.
- Support endoscopic insertion of nasogastric/nasojejunal feeding tubes.
- Endoscopists will state whether the tube is safe to use on the Unisoft endoscopy report.

Purchasing and stores department:
- Ordering and maintaining stock levels of nasogastric tubes that meet the following criteria:
  - CE accredited
  - Fully radio-opaque (NPSA 2011)
  - Externally visible length markings to enable accurate measurement, identification and documentation of their position (NPSA 2011).
  - Universal ENFit connectors
  - Polyurethane material

Medical staff:
- As part of a multi-disciplinary team, make the decision to insert tube following appropriate assessment and consultation with the patient /carer and other team members.
- Lead on ethical decisions in conjunction with multi-disciplinary team taking into consideration family/carer views including interpretation of advance directives.
- Order x-ray imaging when required and review and report results following local policy stated in section 14.3.2
- Out of hours responsibility for X-Ray interpretation resides with middle grade (SpR) and/or Consultant who requested the original X-Ray.
- Where there is regular difficulty obtaining aspirate with a pH of less than 5.5, it may be necessary for the senior medical staff to make a decision on how to manage the nasogastric tube feeding. All decisions and rationale should be documented in the clinical notes. (NPSA 2011)
- Prescribe treatment, taking into consideration factors such as drug nutrient interactions and clinical need.
- Treat complications
- Monitoring of biochemical and other laboratory parameters, e.g. urea and electrolytes.

Radiology Department

Support a ‘hot reporting’ process which allows x-rays post insertion to be reviewed by a radiologist during core hours.

Radiographers:
- Ensure that the nasoenteric tube can be clearly seen on the x-ray to be used to confirm tube position.
- Adjust the exposure of the x-ray to allow the tube to be visible to the bottom of the film.
- Adjust the x-ray film to show the bottom of both hemi-diaphragms in the midline and as much of the abdomen as far as possible below the diaphragm.
Radiologists:

- Review and report the position of the nasoenteric tube
- Complete the NG safety sticker in the patients clinical notes (placed immediately following NG insertion) (NG tubes only)
- **If the tube positioned in lungs** - give the order for the tube to be removed immediately

Pathology department:

Provision of laboratory test results and advice to support clinicians and other health professionals in optimising the provision of nutrition to patients.

### 4. PROCESSES AND PROCEDURES

#### 4.1 REFERRALS

All patients starting nasoenteric feeding should be referred to a dietitian. High risk patients, see section 4.2 below, should be referred to a specialist with expert knowledge of NG tube insertion and management.

**NJ TUBES:** Non-surgical patients should be referred to the gastroenterology department for endoscopic assessment.

#### 4.2 RISK ASSESSMENT

- The decision to insert a nasoenteric tube for the purpose of feeding must be made following careful assessment of the risks and benefits by at least two competent health care professionals including the senior doctor responsible for the patient’s care.
- The decision to initiate enteral feeding should involve the patient, carer/family, and members of the multi-disciplinary team including speech and language therapists and dietitians.
- The indication and rationale of the route and type of tube for enteral feeding will be clearly written in the patient’s medical notes. As a minimum, documentation should include signed, dated and timed entry, of the process of initial risk assessment that evaluates the benefits against the risks of introducing a nasoenteretic tube for the purpose of feeding.

Patients requiring feeding tubes should be assessed for contraindications and any other medical conditions that will place them at high risk of developing complications related to tube feeding.

Specialist advice must be sought if the patient has:

- maxillo-facial disorders
- laryngectomy
- recent radiotherapy to head and neck
- mucositis
- any disorder of the oesophagus e.g. varices, stricture.
- nasal C.P.A.P.

High Risk also includes patients who:

- are comatose/semi-comatose
- are ventilated/sedated
- have a swallow dysfunction
- have recurrent retching/vomiting
- need to be nursed prone
The above group of patients are at a high risk of incorrect tube positioning, dislodgement and aspiration. Patients falling within the above categories will have a risk-benefit assessment with the aims of tube feeding clearly documented in the patient’s notes. (See appendix 1 for Decision Tree for Nasogastric Tube Assessment and Insertion)

4.3 INDICATIONS

NG tube feeding should be considered for patients who:

- are malnourished.
- have a functioning gastrointestinal (GI) tract.
- require short-term tube feeding (up to 4-6 weeks).
- require long-term tube feeding if an alternative route is inappropriate or not possible, i.e. Percutaneous Endoscopic Gastrostomy (PEG).
- are unable to fulfil their nutritional requirements with normal /modified diet ± nutritional supplements.
- are not predicted to fulfil their nutritional requirements with normal / modified diet ± nutritional supplements.
- have increased nutritional requirements e.g. sepsis, trauma, post-op stress & burns.

NJ feeding should be considered for patients with:

- documented gastroparesis
- gastric stasis secondary to paralysing agents required for ventilation
- delayed gastric emptying despite treatment with prokinetics
- severe acute pancreatitis
- pancreatic or duodenal injury
- carcinoma of oesophagus or stomach (where NG or gastrostomy feeding is inappropriate)
- upper gastro-intestinal fistulae
- recent upper GI surgery
- recent hepatobiliary surgery
- Pyloric stenosis

4.4 CONTRAINDICATIONS

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<th>Absolute</th>
<th>Relative</th>
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<tr>
<td>Non-functioning GI tract e.g. ileus.</td>
<td>Oesophageal varices</td>
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<td>Large gastric aspirate and/or high risk of aspiration (NG only).</td>
<td>Mucositis</td>
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<td>Intractable vomiting not resolved by anti-emetics (NG only).</td>
<td>Vomiting responding to anti-emetics</td>
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<td>Basal skull fracture, as the tube may enter the brain if incorrectly positioned (oro-gastric positioning may be appropriate if insertion under endoscopic/radiological vision).</td>
<td>Recent radiotherapy to head and neck</td>
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<td>Intestinal obstruction</td>
<td>Advanced neurological impairment</td>
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<td>Obstructive pathology in oropharynx or oesophagus preventing passage of the tube e.g. stricture, tumour, pharyngeal pouch. Procedure may need to be done under endoscopic or fluoroscopic control. Specialist input advised.</td>
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<td>Malabsorption</td>
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<td>Patients with severe immuno-suppression during chemotherapy</td>
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<td>Impaired gastrointestinal motility</td>
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<td>Neuromuscular blocking agents</td>
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<td>Post abdominal surgery</td>
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4.5 CONSENT

- Prior to insertion of an enteral tube, the procedure and any risks should be explained to the patient so that informed consent, written/verbal/signage, can be obtained from the patient. The patient’s consent must be recorded in the patient’s notes, in compliance with East Cheshire NHS Trust Policy.
- If the patient is unable to give informed consent and in the absence of a patient’s advanced decision regarding treatment, or a registered individual who has lasting power of attorney (Mental Capacity Act 2005), the lead clinician is responsible for any decision to withhold, give, or withdraw, a medical treatment, which includes provision of food and fluid via a feeding tube.
- Where possible a multidisciplinary approach should be taken when deciding on the appropriateness of enteral feeding for a patient. For severely debilitated patients, the ethical, medical and legal implications of long term tube feeding need to be considered.
- The goals of the treatment should be clearly identified in the patient’s medical notes.
- Evidence of discussion with family members, where appropriate, is required.

4.6 TUBE STANDARDS

All nasoenteric tubes used for administration of feed/fluids and medication must have the following criteria:

- CE accredited
- Fully radiopaque
- Externally visible centimetre markings along the length of the tube
- Appropriate length for the purpose of the tube (92cm standard length for adults)
- ENFit connector
- Polyurethane material
- Appropriate lumen size for purpose (8 and 10Fr tubes are recommended, preferring the larger bore if the patient requires multiple medications and/or energy dense feed)

4.7 NASOGASTRIC TUBE INSERTION

- Placement should be delayed if there is insufficient experienced support available to accurately confirm nasogastric tube placement (e.g. at night), unless clinically urgent, and that the rationale for any decisions made is recorded in the patient’s medical notes.
- The procedure will be carried out by or supervised by an appropriate healthcare professional who has received training in the procedure and has been assessed as competent. More advanced skills may be required e.g. inserting tubes on ventilated patients in ICU. Additional training should be sought if required. Guidance for the procedure can be found in Appendices 1 - 5
- The tube must not be flushed with any fluids following initial tube placement until the position of the tube has been confirmed as within the stomach.
- Internal guide wires/ stylets must NOT be lubricated before gastric placement has been confirmed.
- It is not essential to leave the stylet in place if x-ray verification is required, however it may be helpful to leave it in until position is confirmed, in case the tube needs to be moved. The stylet must not be reinserted whilst the nasogastric tube is in the patient.
- Documentation must include completion of the nasogastric safety sticker which must be affixed to the patient’s clinical notes as well as any variances during the procedure.
- Clinical waste should be disposed of as per Trust policy.

(See appendix 2 for full procedural guidance)
4.8 CONFIRMATION OF NG TUBE POSITION

Incorrectly positioned tubes leave patients at risk of serious harm from feed entering the lungs due to direct placement in the lungs or reflux and aspiration (NPSA 2005).

- **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.

### 4.8.1 Who should check the tube position?

- Any health professional/carer/patient prior to using the tube.
- In the majority of cases nurses pass the tube and manage subsequent feeding. A nurse may be involved in training a patient/carer to manage the tube.

### 4.8.2 When to check the position of the tube

- After initial tube insertion
- At least once per shift if continuous feeds are in progress (stop feed for 30 mins prior to pH check).
- Before each bolus feed, fluid or drug administration.
- If the patient complains of discomfort or feed reflux in the throat or mouth.
- If the patient suddenly shows signs of respiratory distress, e.g. breathlessness, strider, cyanosis or wheezing.
- Vomiting, violent retching, or deep suction.
- Severe coughing bouts.
- If the measurement marking the tube’s exit from the nose has changed.
- If the tube length appears to have changed.
- Following transfers from other clinical areas, if feed in progress.

### 4.8.3 How to check the position

**A. FIRST LINE METHOD: PH testing is mandatory following all tube insertions**

- **PH testing**: Safe range ≤ 5.5. Each test result must be documented on a chart kept at the patient’s bedside.
- An attempt at pH testing is mandatory following every nasogastric tube insertion even if the criteria for x-ray testing are met. This will allow for a baseline recording. (see appendices 3-8 for guidance in obtaining aspirate, assessing placement and documenting evidence)

**Use of equipment for pH monitoring**

- Tube position must be checked using pH indicator strips that are CE marked, intended by the manufacturer to test human gastric aspirate and have a clear definition between pH 5-6 (NPSA 2005, 2011).
- Gastric aspirate must not be syringed into the syringe wrapping/cover and the reagent strips dipped into the aspirate as the acid may react with the plastic and alter the pH reading (NPSA 2005). Use reagent strips as per manufacturer’s guidelines.
- pH strips must be used and stored according to manufacturer’s instructions. The reagent section should not be contaminated before use through handling or inappropriate storage. The lids must be kept on the pH strip containers when not in use, otherwise the sensitivity of the reagent strip is reduced.
• Each patient must have their own container of pH strips for the duration that the tube is in situ, in order to prevent cross contamination.
• Syringes must be uncontaminated prior to pH testing.

B. SECOND LINE METHOD: X-ray

Only for the following indications:

- The patient has altered anatomy e.g. known large hiatus hernia, pharyngeal pouch
- Unable to obtain aspirate
- Testing of aspirate is inconclusive.
- Difficult tube insertion with serious doubt about tube position
- Fractured base of skull.
- Recent radiotherapy/surgery to head and neck.
- The patient is unconscious with no gag reflex (ICU protocol)

Criteria for requesting, imaging and assessment

- X-ray requests must clearly state that the purpose of the x-ray is to establish the position of the nasogastric tube for the purpose of feeding.
- The patient’s clinical notes will accompany the patient to the x-ray department
- The whole of the nasogastric tube must be clearly seen on the x-ray to be used to confirm tube position.
- The x-ray film must show the bottom of both hemi-diaphragms in the midline and as much of the abdomen as far as possible below the diaphragm.
- The clinician reporting the x-ray must complete the NG safety sticker in the patient’s medical notes to include:
  - Date/time of X-ray
  - Most recent X-ray viewed
  - 4 criteria to be met to verify safe position
    1. Does the tube path follow the oesophagus/avoid the contours of the bronchi?
    2. Does the tube clearly bisect the carina or the bronchi?
    3. Does it cross the diaphragm in the midline?
    4. Is the tip clearly visible below the left hemi-diaphragm?
  - State plan i.e. remove tube or safe to feed
  - Signature

See appendix 5, NPSA nasogastric tube x-ray interpretation aid.

X-rays that do not meet the above criteria will not allow accurate interpretation of nasogastric tube placement and should be redone.
- Any tubes identified as in the lung must be removed immediately, whether in the x-ray department or clinical area.
- In core hours, x-rays will be checked by a senior radiologist, outside these hours the responsibility assessing the position of the tube lies with the middle grade (SpR) and/or consultant requesting the x-ray.
- The x-ray image must be reviewed using high resolution computer screens. Portable device screens must not be used to report tube position as may be of inadequate quality to diagnose misplaced tubes. (Misplacement incidents must be report via East Cheshire NHS Trust risk management reporting systems.
- X-ray should not be used routinely to confirm tube position during subsequent use (NPSA 2005).
4.9 UNSAFE METHODS OF CHECKING TUBE POSITION

- Auscultation of air insufflated through the feeding tube (‘whoosh’ test)
- Testing acidity/alkalinity of aspirate using litmus paper
- Interpreting absence of respiratory distress as an indicator of correct positioning
- Monitoring bubbling at the end of the tube
- Observing the appearance of feeding tube aspirate

4.10 DOCUMENTATION

- The NG safety sticker must be affixed to the patient’s clinical notes and completed by the staff member
  a) inserting the NG tube
  b) carrying out the pH test
  c) reporting the x-ray result

- A nasogastric monitoring form must be commenced and used to record subsequent assessment of tube position (see appendix 8)

- All variances and complications must be recorded in the patients clinical notes.
- All activity relating to enteral feeding will be recorded in the patient’s notes and on appropriate charts as per Trust policy.
- Refer to individual guidelines for enteral feeding for detailed requirements relevant to the type of feeding tube.

4.11 ESCALATION

If after 3 attempts NG insertion has failed or pulled out by the patient on three consecutive occasions, escalate as soon as possible to an experienced practitioner (senior nurse/clinician/nurse specialist). If the tube is repeatedly removed by a patient, consider a nasal retention device/bridle providing it is appropriate and safe for the patient (Refer to CNSG008 Policy and Procedures for insertion and Management of Nasal Retention Device (Bridle).

4.12 NASOJEJUNAL TUBE – POSITION CHECKS PRIOR TO USE

- Endoscopically placed tubes may not need to be x-rayed prior to use. The endoscopist should state whether x-ray is required on the endoscopy report.
- The external length of all jejunal tubes should be measured, marked and documented in the clinical notes/endoscopy report and on the nasogastric/nasojejunal monitoring chart.
Aspiration

Aspirate is difficult to obtain from the small bowel and pH will be > 5.5, therefore suboptimal as an indicator of tube position. Additional positional checks must be undertaken as follows:

1. Check the measurement at the exit from the nose, if significantly different from the distance recorded during placement (> 10cm), report to clinician.
2. Check the patient's mouth for looped tube
3. Recheck the tube position following vomiting episodes and if the patient is suffering from increased respiratory distress.

If the patient is nauseated or vomiting, the NJ tube should be aspirated. If large volume aspirate is obtained +/- the aspirate is < ph5.5, this may indicate that the tip of the tube has migrated to the stomach. Any feed or medication being administered through the tube at this time should be stopped and advice sought from clinician/specialist nurse.

If position of the tube is in doubt, consider abdominal x-ray.

4.12 MONITORING

Regular monitoring will be carried out to ensure that safe and effective nutritional support is provided for patients receiving enteral nutrition. It will include clinical (bedside), nutritional and biochemical parameters. Refer to CNSG 017 Guidelines for Assessment and Monitoring of Patients Receiving Enteral Feeding.

4.13 MAINTENANCE OF THE TUBE – PREVENTION OF BLOCKAGE

Nasoenteric tubes are usually fine bore and have a higher potential to block. Regular and effective flushing is essential. Prior to flushing Full compliance with hand hygiene and personal protective equipment must be maintained as per Trust Infection Prevention and Control Good Practices Policy.

Jejunal tubes can be more complex to insert and may involve procedures that carry a degree of risk of complications to the patient. Therefore, every effort must be made to minimise the need for replacement in the instance of blocked or displaced tube.

4.13.1 Administration of water

In the hospital setting, tap water is suitable for flushing, providing that it is:

- Kept in a lidded container
- Changed twice a day
- Not contaminated by dipping the syringe into the jug to draw up water (pour the water into a cup first).

Use sterile water if:

- The patient is immuno-compromised
- The feeding tube is positioned in the small intestine (NJ)
- Large volumes of water are required to be given via a sterile reservoir i.e. an Abbott Flexitainer.

The sterile water bottle must be labelled with the patient’s name, date and time of opening. It must be discarded after 24 hours.
Community Patients (NG tubes)

Use cooled, boiled water, prepared daily, stored in a lidded container at room temperature

4.13.2 Syringes

Syringes meet the following criteria:
- NPSA compliant
- ISO Standard for enteral nutrition (ISO 80369-3) – ENFit connectors for enteral devices
- Single episode use in the hospital
- Reusable use in the community (refer to manufacture’s recommendations for cleaning process http://www.gbukenteral.com/pdf/Dishwasher-instructions-syringes.pdf )

4.13.3 When to flush

Flush the tube with a minimum of 30-50mls of water:
- Before and after administration of feed
- Before and after administration of each type of medication
- If the patient is disconnected from the feed for a short period of time.
- Leave a column of water in the tube during the rest period.
- 4 hourly if the tube is at high risk of blocking e.g. a jejunal tube
- Following aspiration to check the enteral tube position

4.13.4 How to flush

How to flush

Moderate pressure should be applied with the plunger when flushing feeding tubes.
4.14 ADMINISTRATION OF FEED

Refer to Trust policy for administration of feed and fluid via enteral feeding tubes.

4.15 ADMINISTRATION OF MEDICATION

Prior to administration, the patient’s medication must be reviewed by a pharmacist to advise on appropriate drug preparation and dosage as the absorption and efficacy of certain drugs will alter dependent on the tube’s position in the gut. The prescribing clinician must be aware that the preparation is to be given via a nasoenteric tube and its location within the gut.

If the patient has jejunal tube, it may be necessary to consider passing a second tube into the stomach or use a double lumen tube so that drugs can be administered into the stomach.

4.16 ENTERAL FEEDING COMPLICATIONS

- Complications should be dealt with as soon as possible.
- Any intervention and outcome should be recorded in the patient’s medical/nursing notes.
- Refer for specialist advice if unable to manage the complication.
- For further information on managing systemic complications, see Trust Policy for Administration of Feed and Fluid via Enteral Tubes.

4.17 DISCHARGE ARRANGEMENTS FOR PATIENTS WITH A NASOGASTRIC TUBE

Before a patient is discharged home, the following actions are required:

4.17.1 Referrals

- Dietitian
  - Refer at least three to five weekdays before estimated date of discharge, to allow time for ordering equipment, adjustment of feeding regimen and training of patient and carers.
- District nurses
- Pharmacist (if medication needs modifying)

4.17.2 Risk assessment

A full multidisciplinary supported risk assessment is should be made and documented before a patient with a nasogastric tube is discharged from acute care to the community (NPSA recommendation)

Nasogastric tube use in the community is uncommon, therefore community nursing staff are generally not up to date with the latest guidance and fully competent in insertion and management of nasogastric tubes, therefore the plan must include readmission to an agreed area for reinsertion of a nasogastric tube.

4.15.3 Action plan

Prior to discharge, a clear plan must be agreed in the event of an accidentally removed or blocked tube.

4.17.4 Training

Prior to discharge the patient and/or carers will be taught how to:
Aspirate and test for pH value
Set up and administer feed/fluids/medication
Store and dispose of equipment
How to maintain oral hygiene
Give nasal care if NG fed

Training requirements may delay discharge, particularly if the patient is being discharged to a nursing home where the staff have limited experience and a large number of staff require training/updating. Forward planning is advised.

Training undertaken must be documented in the patient’s clinical records together with evidence of assessment of competency.

4.17.5 Information and contact details required

The patient will be given contact details for:
- Home enteral feeding dietitian
- Specialist nurse
- Company providing the feed and equipment

The patient will be given written information for the following:
- Pump manual
- Gastrostomy/NG/NJ care booklet
- Syringe reprocessing leaflet
- Information Booklet for ordering replacement equipment
- Instructions for use of accessories e.g. pH strips
- Feeding regimen indicating continuous or bolus feeding.

4.17.6 Equipment to be sent home with patient

The patient will be discharged with sufficient feed and equipment to last until the first home delivery. To include:
- Feed
- ENFit Syringes
- Giving sets and reservoir if required
- pH strips
- Spare tube
- Pump - not ward stock.

Ward stock of feed pumps are on loan to the Trust and are the property of the contractor nutrition company. Feed pump stock is audited and must not leave the hospital. Contact the dietetics dept 3-5 days prior to discharge to arrange for a community pump.

4.18 MANAGEMENT OF COMMUNITY PATIENTS WITH A DISPLACED OR BLOCKED NASOGASTRIC TUBE

If the supporting community team are unable to manage the complication i.e. blocked or accidentally removed tube, the patient will need to come to hospital for replacement as per the agreed discharge plan.
4.19 ADMISSION OF PATIENTS ON NASOGASTRIC ENTERAL FEEDING

- Patients will be assessed by the medical team as safe for enteral feeding.
- If safe, the patient should continue with their established regimen until dietetic review
- Refer the patient to the dietetics department. See appendix 11 for management flowchart

4.20 REMOVAL OF NASOENTERIC FEEDING TUBES

Tubes should only be removed if patients are meeting their nutritional requirements via an alternative route. Nasogastric and Nasojejunal tubes can be removed by pulling. Refer to specialist if unsure.

5.0 MONITORING AND COMPLIANCE WITH THE POLICY

5.1 Audit

- Senior sisters are responsible for completing spotcheck audits of patients treated with a nasogastric feeding tube (see appendix 8 for proforma)
- for audit template). Audit outcomes will be fed back at Quality Forum and Directorate SQS meetings.
- A central database will be kept by the dietetics department (shared drive) to facilitate regular audit.
- Annual audit will be carried out and reported at the medical and surgical audit and NNSG meeting
- Chair of Nutritional Steering Group will co-ordinate and ensure that the Patient Safety Alert action plan is monitored quarterly as a standing item agenda.

5.2 Training and Competency

- Medical and nursing staff caring for patients with NG tubes must be competent in procedures and care processes relating to tube insertion and management.
- It is the responsibility of individual health professionals to maintain and update their knowledge, skills and competencies in the management of enteral tube feeding and keep their own record of continuing professional development.
- All Band 5 nursing staff starting at the Trust are expected to complete the clinical skills for nurses course and to be assessed as competent in the insertion and management of nasogastric tube by a recognised assessor.
- Identified ward staff with advanced skills in nasogastric tube placement will receive annual training updates from a specialist in nasogastric tube management and direct line managers will take responsibility to embed the requirement via individual appraisal and personal learning plan development.
- A competency based learning package is available to underpin the required level of knowledge, skills, competency and procedural documentation compliance, in order to support and guide practice for identified key staff based on wards with a higher usage of nasogastric tubes (Ward 1, 3 and ICU).
- Competency will be assessed using the Trust’s validated competency framework document for insertion and management of a nasogastric tube for adults.
- All staff completing nasogastric tube training and competency assessment will be recorded on a central database, established via the clinical skills facilitator, to maintain accurate training records and evidence annual updates.
6.0 REFERENCES

Colgiovanni L (1999) Taking the tube Nursing Times supplement 95(21)63-66

Marsden Manual (2011) 8.1 Procedural guideline for the insertion of a nasogastric tube without using an introducer e.g. Ryles tube.

Medical Devices Agency 2004 Enteral feeding tubes (Nasogastric) MDA 2004/026


http://www.nrls.npsa.nhs.uk/alerts/?entryid45=129640


APPENDIX 1  

Decision Tree for Nasogastric Tube Assessment and Insertion

Patient requires NG tube

- High Risk Conditions:
  - Skull fracture
  - Altered UGI anatomy e.g. stricture, hiatus hernia, pharyngeal pouch, recent surgery/radiotherapy to UGI tract
  - Mucositis
  - Recurrent retching/vomiting

- Functioning GI tract
  - yes
  - no

- Feeding
  - yes
  - no

- Drainage
  - Insert appropriate tube for gastric drainage
  - Complete NG tube insertion and monitoring forms – appendices 6 - 8

- Is a trained and competency assessed member of staff available to insert the tube? Does the individual have sufficient competency for this particular patient?
  - yes
  - no

- Refer to specialist
  - GI specialist nurse
  - Gastroenterology team
  - Endoscopy department

- Consider parenteral nutrition
  - If complex refer to Nutrition support team

- Discuss procedure with patient and obtain verbal consent

- Request assistance from a competent practitioner (wards 1, 3 and ICU)

- Document rationale for NG feeding in patient’s clinical notes including discussion with patient and consent/best interests decision

- Insert and manage NGT as per policy/guidance

- Complete NG safety sticker and affix to patients clinical notes
APPENDIX 2  Procedural guideline for insertion of a feeding nasogastric tube

Equipment required: -

<table>
<thead>
<tr>
<th>Gloves</th>
<th>Lubricating jelly</th>
<th>Water and straw (if patient safe to swallow)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 60ml ENFit syringe</td>
<td>CE accredited pH strip, Tissues</td>
<td>CE accredited NG tube</td>
</tr>
<tr>
<td>Receptacle to collect aspirate, Securing tape/dressing</td>
<td>Spoon – to help trigger swallow if dysphagic</td>
<td>(choose size appropriate for patient and treatment needs)</td>
</tr>
<tr>
<td>Waste bag.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Procedure**

<table>
<thead>
<tr>
<th>Action</th>
<th>Rational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to the procedure, check the medical and nursing notes for complications, e.g. anatomical variations due to surgery or cancer.</td>
<td>These may affect the procedure and result in further complications. Patients with head injury or facial trauma may have the feeding tube passed through the mouth and down into the stomach to bypass nasal damage and cerebral oedema.</td>
</tr>
<tr>
<td>Assess the patient’s requirements.</td>
<td>The appropriate tube is inserted to meet the patient’s needs and clinical condition and that the tube is acceptable and comfortable.</td>
</tr>
<tr>
<td>Explain the procedure to the patient (even if the patient appears not to understand).</td>
<td>To ensure that the patient understands and is able to give consent, also to co-operate with the procedure.</td>
</tr>
<tr>
<td>Arrange a signal so that the patient can communicate with the nurse during the procedure e.g. raise a hand.</td>
<td>Helps to alleviate fear as the patient has some control over the procedure.</td>
</tr>
<tr>
<td>Assist the patient in a semi-upright position. Support the head in a slightly forward position.</td>
<td>Assists swallowing and helps prevent tracheal placement if the swallow is compromised.</td>
</tr>
<tr>
<td>Check that the nostrils are patent by asking the patient to sniff with one nostril closed. Repeat with the other side. Alternate nostrils if replacing a tube.</td>
<td>Helps identify potential obstruction. Prevents nasal irritation and potential ulceration.</td>
</tr>
<tr>
<td>Wash hands and put on non-sterile gloves and an apron.</td>
<td>Minimises cross infection (Anderton 1995).</td>
</tr>
<tr>
<td>Unpack the tube, close the end connectors. If the tube has a guide wire, gently push it into the tube until it is fixed (see manufacturer’s guidelines in packet). Check that the tube is not kinked.</td>
<td>Prevents the tube from coiling back on itself during insertion.</td>
</tr>
<tr>
<td>Place the tip of the tube (the distal opening, if the tube is weighted) at the xiphisternum and measure up to the tip of the nose and then to an ear lobe (NEX measurement). Note the measurement on the tube.</td>
<td>Ensures that the correct length of tube is placed in the stomach.</td>
</tr>
</tbody>
</table>
**Action**

Lubricate the tube. Use a thin coating of water based jelly.

Hold the tube straight rather than coiled in your hand and insert the tip of the tube into the chosen nostril, advancing it, horizontally, gently along the floor of the nostril, parallel to the nasal septum, to the nasopharynx and then oropharynx. The patient may sneeze. Reassure. If resistance is met, withdraw slightly and alter the angle of insertion, otherwise try the other nostril.

If the patient is able to swallow small sips should be taken at this stage. An assistant may be required to help give thickened fluids to swallow.

**Rational**

Facilitates easy passage of the tube.

Follow the natural anatomy of the nose.

The swallowing action places the epiglottis over the trachea so allowing the tube to enter the oesophagus. Also the patient has something else to focus on.

**Techniques to aid insertion if dysphagic:**

- Placing a cold spoon on the tongue may initiate a swallowing reflex.
- Rotate the tube in your hand so that the tip points slightly upwards. This will position the tip in the correct position on the nasopharyngeal wall.
- Tip the patient's chin towards the chest.
- Advance the tube through the nostril and into the nasopharynx until resistance is felt, there may be an involuntary swallow reflex stimulated by the tube. Advance the tube with the swallow. If no reflex, advance the tube slowly or the tube will back up into the mouth. Gentle pressure will allow the tube to pass into the oesophagus.

**CAUTION**

- Never advance the tube against resistance, pull back slightly and retry.
- If the patient shows signs of respiratory distress i.e. coughing gasping or cyanosis, the tube may have entered the trachea. Pull the tube back or remove to allow time to recover. If respiratory distress is prolonged or worsens, seek medical assistance.

Advance the tube down the oesophagus with successive swallows until the correct measurement or mark is seen at the nostril.

Check the position (see appendix 3 below)

**NB**

- **DO NOT FLUSH** the tube before gastric placement has been confirmed.
- Internal guidewires/ stylets should NOT be lubricated before gastric placement has been confirmed.

To verify safe positioning in the stomach

**CAUTION**

Water activation of the lubricant may give an inaccurate low pH result. NPSA/2012/RRR001

Fix the tube in position following the aspirate check as the tube may need to be moved to obtain aspirate.

Dispose of clinical waste as per Trust policy. The guide wire must be placed in the sharps bin.

Complete NG safety sticker and affix in the patient’s clinical notes. Document any variances.

Evidence of care and auditing requirement
## APPENDIX 3  Procedural Guidance To Obtain And Check Gastric Aspirate

The table below suggests techniques to maximise successful aspiration of gastric contents.

**Patience is required** - Studies suggest a 90% + success rate in obtaining aspirate.

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place a 60cc uncontaminated ENFit syringe on to the access port and pull back the plunger</td>
<td>To withdraw fluid from the stomach</td>
</tr>
<tr>
<td>Place aspirated fluid on to a CE accredited pH strip and compare with the colour chart on the pH strip container (0.5mls is sufficient to cover the pH strip). Record the corresponding result.</td>
<td>First line testing method as per NPSA alerts</td>
</tr>
</tbody>
</table>

#### If no aspirate:

- Insert 10 - 20 mls of air, then aspirate. Repeat 2-3 times, aspirating after each injection of air.

#### If no aspirate:

- Alter the position of the tube and retry.
- Lie the patient on their left side and retry.

#### If no aspirate:

- If safe to swallow offer an acidic drink such as orange juice.
- If unsafe, give mouth care to stimulate acid production, then retry.

Flush the tube with water following successful aspiration

Gastric fluid causes the protein in the feed to coagulate and increases the risk of tube blockage.

#### PH result and action required

If <pH 5.5 it is most likely safe to use the tube

**HOWEVER**

X-ray may still be indicated if:

- Known abnormality/recent treatment to UGI tract
- Fractured base of skull
- Difficult insertion

If >pH 5.5, consider causes for a raised pH and if appropriate wait 30 mins and retest.

Causes include:

- Medication i.e. H2 antagonists and proton pump inhibitors which inhibit or reduce acid production. PH value will be raised.
- Bile
- Recent food/fluid
- Lung placement

Back to index
APPENDIX 4  Decision tree for assessing NG placement in ADULTS

- Estimate NEX measurement (Place exit port of tube at tip of nose. Extend tube to earlobe, and then to xiphisternum and note measurement marking on the tube)
- Insert fully radio-opaque nasogastric tube for feeding (follow manufacturer’s instructions)
- Confirm and document secured NEX measurement
- Aspirate with a syringe using gentle suction

Aspirate Obtained?

No

Try each of these techniques to help gain aspirate:
- If possible, turn patient onto left side
- Inject 20-30ml air into the tube using a 60ml syringe
- Wait for 15-30 minutes before aspirating again
- Advance or withdraw tube by a few centimeters
- Give mouth care to patients who are nil by mouth (stimulates gastric secretion of acid)
- Do not use water to flush

Aspirate Obtained?

No  X-ray

Yes

Wait 30 mins and retest. If still >pH 5.5, proceed to x-ray: ensure reason for x-ray documented on request form.

Community patients: Contact department/specialist as agreed in discharge plan.

If pH between 1 and 5.5 and no known abnormality to UGI tract and no cause for concern during insertion

PROCEED TO FEED or USE TUBE Complete safety sticker in NG pack and place in clinical notes and subsequently on bedside NG monitoring form before each feed/medication/flush.

If pH NOT less than 5.5

Yes

Senior clinician/radiologist (trained and competent in reporting X-rays) available to review x-ray and document confirmation of nasogastric tube position in stomach

No

DO NOT FEED or USE TUBE Consider re-siting tube or call for senior advice

- A pH of between 1 and 5.5 is reliable confirmation that the tube is not in the lung, however it does not confirm gastric placement as there is a small chance the tube tip may sit in the oesophagus where it carries a higher risk of aspiration. If this is any concern, the patient should proceed to x-ray in order to confirm tube position.
- Where pH readings fall between 5 and 6 it is recommended that a second competent person checks the reading and/or re-tests.
APPENDIX 5 NPSA Nasogastric Tube X-ray Interpretation Aid

Patient Safety Alert
NPSA/2011/PSA002
10 March 2011

Nasogastric tubes: x-ray interpretation aid

a. Is nasogastric tube feeding the right decision for this patient?
b. Is this the right time to place the nasogastric tube and is the appropriate equipment available?
c. Is there sufficient knowledge/expertise available at this time to test for safe placement of the nasogastric tube?

To confirm gastric position of the nasogastric tube, ask:

- Does the tube path follow the esophagus/esophageal contours of the bronchus?
- Does the tube clearly bisect the carina or the bronchus?
- Does it cross the diaphragm in the midline?
- Is the tip clearly visible below the left hemi-diaphragm?

Proceed to feed only if all criteria are met. If in any doubt repeat a x-ray or call for senior help.

Below are two examples where the nasogastric tube has been incorrectly identified as being in the stomach:

- Radiograph 1
  - Radiograph 1 shows the tip of the nasogastric tube above the diaphragm and on the right hand side of the thorax. The presence of rib G makes interpretation of the radiograph more difficult.

- Radiograph 2
  - Radiograph 2 shows the tip of the nasogastric tube apparently below the left hemidiaphragm but the tube clearly follows the contours of the left bronchus. In fact, the tube is positioned in the left lower lobe of the lung.

X-rays must always be interpreted by someone assessed as competent to do so, and the decision to feed a patient must be documented in the patient's medical notes, dated, timed and signed by that person.
APPENDIX 6  Nasogastric (NG) Tube Insertion Assessment Form

Patient Details: Fix label if available
Name: .................................................................
Date of Birth: ............................
Hospital No: .......................... NHS No: ..........................

Decision Maker: .................................................................
Title: ............................................. Date/time: ............................. Ward: .................
Reason for insertion: Feeding ☐ Medication ☐ Fluids ☐ Decompression ☐

Assessment and Preparation:


VERY HIGH RISK OF INSERTION COMPLICATION
- Fractured base of skull
- Upper GI obstruction
- Recent surgery / radiotherapy to upper GI tract / larynx?

Yes

Refer to specialist / nutrition support team or expert practitioner prior to insertion.

No

HIGH RISK OF: incorrect positioning, dislodgement and aspiration
- Altered state of consciousness / ventilated
- Swallow dysfunction / nursed prone
- Recurrent retching vomiting?

Yes

Consider referral to specialist / expert practitioner / nutrition support team for:
- Insertion and management advice
- Alternative feeding methods

No

Insert tube as per Trust policy and commence NG monitoring form

A maximum of 3 attempts at NG insertion is recommended prior to seeking more expert help/advice.
If out of hours, wait until more expert help is available.
Do not flush or use the tube before the position is verified. pH testing is the first line test. Refer to decision tree in Trust NG guidelines for insertion and confirmation of position.

Refer to decision tree overleaf for assessing NG placement in adults and commence NG tube monitoring form

NG Safety Sticker completed and affixed to clinical notes ☐ Baseline pH value............... 

Date...........Name..........................Signature..........................Position...............
**APPENDIX 7 ALGORITHM TO ASSESS IF NG TUBE STILL IN THE STOMACH (AFTER CONFIRMATION OF GASTRIC PLACEMENT POST INSERTION)**

**NO ASPIRATE:** Try the following:
- Inject 20 - 30ml air into the tube using a 60ml enteral syringe
- If possible, turn patient onto left side
- Alter the position of the tube
- Repeat the above and retry

**IF STILL NO ASPIRATE:** CHECK FOR TUBE DISPLACEMENT AS BELOW

- **HAS THE EXTERNAL LENGTH OF THE TUBE CHANGED?** Check cm mark at exit from nose and compare with insertion data on safety sticker and NG monitoring charts.
- **HAS THE PATIENT VOMITED/HAD DEEP SUCTION?**
- **HAS THERE BEEN AN INCREASE IN THE PATIENT’S RESPIRATORY DISTRESS** e.g. breathlessness, strider, cyanosis or wheezing.
- **IS THE NG TUBE VISIBLE IN THE MOUTH?**

**REPOSITION TUBE OR REMOVE AND REPLACE** – repeat confirmation checks as seen in decision tree for NG tube position check.

**INCONCLUSIVE ASPIRATE (pH > 5.5) – CONSIDER THE FOLLOWING WITH TUBE DISPLACEMENT CHECKS.**

- **RESIDUAL FLUID IN TUBE**
  Flush a small amount of air through the tube to clear residual feed/fluid then retry.

- **DILUTION OF GASTRIC ACID.**
  1. Recent feed/flush: wait half an hour and retry
  2. Continuous feeds: consider stopping the feed for half an hour. 
  Caution: If the patient is having insulin infusions for tight glycaemic control. Consult with senior doctor/specialist before stopping the feed.

- **MEDICATION:** if on a PPI e.g. lansoprazole/omeprazole or H2 antagonist e.g. ranitidine.
  Look at previous pH readings, if consistently high, treat as normal, if a one off, consider why. Request expert review.

- **TUBE DISPLACEMENT:** Complete displacement checks

**IF REMAIN UNSURE AFTER THE ABOVE, CONSIDER X-RAY.**
Consult a more experienced member of staff prior to requesting an X-ray. Document decision and rationale.
## APPENDIX 8: NASOGASTRIC TUBE MONITORING CHART

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Aspirate PH value</th>
<th>Cm marking at exit from nose</th>
<th>Fixation tape /nasal bridle secure /nostril healthy Y/N</th>
<th>Check X-ray required YES/NO</th>
<th>If yes, document result in clinical notes as per Trust policy</th>
<th>Variations</th>
<th>Initial</th>
<th>2nd opinion initials – if required</th>
</tr>
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<tbody>
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<td></td>
</tr>
</tbody>
</table>

| Ward |  |

**Patient Details:** Fix label if available

Name:  

Date of Birth:  

Hospital No:  

NHS No:  

Review July 2020  
Page 29 of 40
### APPENDIX 9  Senior Sister Nasogastric Tube Insertion Audit Proforma (Feeding Tubes)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Results</th>
<th>Action taken if variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale for NG use documented in clinical notes</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>Inserted by: Position/grade</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Official NG sticker in clinical notes</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>Fully completed (including x-ray section if x-ray undertaken)</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>Time tube placed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If outside core working hours, rationale documented</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>Aspirate attempted</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>pH value</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd attempt if pH &gt;5.5</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>Senior advice requested</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>X-ray check requested</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>Reason for x-ray on request details</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>X-ray reported by: Position/grade</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>Tube removed immediately if misplaced</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>Any evidence of patient harm</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>Type of harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NG monitoring form in use and up to date</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
</tbody>
</table>
### APPENDIX 10 – Proformas for risk assessment and requirements prior to discharge

#### PRE DISCHARGE RISK ASSESSMENT FOR HOME NASOGASTRIC FEEDING

This assessment MUST be completed prior to discharge

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Number:</td>
<td></td>
</tr>
<tr>
<td>Date Assessment Initiated:</td>
<td></td>
</tr>
</tbody>
</table>

**Patient to be discharged to:** Own Home / Nursing Home (*please delete as appropriate*)

<table>
<thead>
<tr>
<th>Tube Care</th>
<th>Date shown</th>
<th>Name &amp; Signature of Registered Nurse</th>
<th>Date Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to check tube position</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of tube</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of feeding equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand hygiene</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flushing NG tube</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration of Medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dealing with tube blockage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dealing with tube displacement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of Nasal Bridle</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeding</th>
<th>Date shown</th>
<th>Name of Registered Nurse</th>
<th>Date Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand feed regimen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration of bolus feeds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connection of feed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setting up pump</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disconnection of feed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pump training completed by Company Nurse on ...................... at .................hrs

**Competency Agreement**

I, the patient / carer* are satisfied with the training received and feel confident to be discharged on my NG feed.

* I accept responsibility to put into practice techniques as per instructions.
* I understand that failure to follow guidelines can result in adverse complications.

**Patient's Name / Carer's Name: (PRINT) .......................................................... ..........................................................

Signature: ........................................... Date: ..........................................................

**Name of Nurse: (PRINT) .......................................................... ..........................................................

Signature: ........................................... Date: ..........................................................

CNSG 006 East Cheshire NHS Trust Policy and Procedures for Nasogastric tube Insertion and Management for Adults.
Pre Discharge Checklist : Nasogastric Feeding
This assessment MUST be completed prior to discharge

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>NHS Number:</th>
<th>Date:</th>
</tr>
</thead>
</table>

| Date Tube inserted: | | |
| Size of NG tube: | | |
| Centimetre mark at nose: | | |
| Planned discharge date: | | |

<table>
<thead>
<tr>
<th>Company Information Pack</th>
<th>Name of Registered Nurse</th>
<th>Signature</th>
<th>Date given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spare tube</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syringes (60ml)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pH strips</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal tapes (to secure tube)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-10 day supply of feed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Giving sets (if appropriate)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reservoirs (if appropriate)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pump and stand (if appropriate)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding regimen</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Contact Details:**

<table>
<thead>
<tr>
<th></th>
<th>TelephoneNumber:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Delivery Service</td>
<td></td>
</tr>
<tr>
<td>Community Dietitian</td>
<td></td>
</tr>
<tr>
<td>District Nurse</td>
<td></td>
</tr>
</tbody>
</table>

**Instructions for patient/carer if tube displaced/blocked (need to document in medical notes).**
Please identify any possible risks:

<table>
<thead>
<tr>
<th>Risks</th>
<th>Action</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Completed by:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Designation:</th>
<th>Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please file in patient's notes. Give a copy to patient/carer.
## APPENDIX 11  Compliance Monitoring Tool

<table>
<thead>
<tr>
<th>Policy</th>
<th>Enteral Feeding Policy for Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Maggie Allen GI Nurse Specialist</td>
</tr>
<tr>
<td>Date of Approval</td>
<td>August 2012</td>
</tr>
<tr>
<td>Date for review</td>
<td>August 2019</td>
</tr>
<tr>
<td>NHSLA Criterion Number (as applicable)</td>
<td></td>
</tr>
<tr>
<td>Approving Committee/Group</td>
<td>Clinical Nutrition Steering Group</td>
</tr>
<tr>
<td>Requirement to be monitored</td>
<td></td>
</tr>
<tr>
<td>Process to be used for monitoring e.g. audit</td>
<td></td>
</tr>
<tr>
<td>Responsible individual/committee for carrying out monitoring</td>
<td></td>
</tr>
<tr>
<td>Frequency of monitoring</td>
<td></td>
</tr>
<tr>
<td>Responsible individual/committee for reviewing the results</td>
<td></td>
</tr>
<tr>
<td>Responsible individual for developing an action plan</td>
<td></td>
</tr>
<tr>
<td>Responsible Committee/group monitoring the action plan</td>
<td></td>
</tr>
<tr>
<td>- NPSA alerts adhered to</td>
<td>Audit</td>
</tr>
<tr>
<td>- Trust policy and guidelines adhered to</td>
<td>Collaboration between dietetics department, clinical matrons and ward managers</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annual</td>
</tr>
<tr>
<td>Responsible individual/committee for reviewing the results</td>
<td>Nutrition Steering Group</td>
</tr>
<tr>
<td>Responsible individual for developing an action plan</td>
<td>Nutrition Steering Group</td>
</tr>
<tr>
<td>Responsible Committee/group monitoring the action plan</td>
<td>Nutrition Steering Group</td>
</tr>
</tbody>
</table>
APPENDIX 12  ADMISSION TO HOSPITAL WITH ENTERAL FEEDING

No

Monday to Friday 8.30-16.30

Yes

Medical condition assessed as safe for enteral feeding

Yes

If no, refer to dietitian when clinically stable

Yes

Contact dietetics dept

Dietitian to:
1. Write correct feed on drug chart
2. Write out feed and fluid regimen on feeding chart

Administer feed and fluids as per dietetic recommendation

What is their usual method of administration?

Bolus feeding
Continue with this method of administration

Has the patient come in with feed?

Yes

Abbott feed

No

Pt may need feed changing to Abbott feed depending on clinical circumstances *

Pump feeding
If the patient is stable and unlikely to pull out the tube, consider pump administration. If not give as bolus admin.

Yes

Give Abbott feed as per emergency feed regimen as per documented medical advice.*
Dr must write feed on prescription chart and sign regimen form

No

Refer to dietetics dept

* The emergency regime gives a reduced amount of feed. If a patient’s clinical condition and medical advice allows, they can continue with a full dose feed as per their normal regimen. If Abbott feed, use Trust pump. If non Abbott feed, give with bolus admin as community pumps cannot be used within the hospital.
APPENDIX 13 Competency Assessment Proforma link

COMPETENCY form for insertion and management

APPENDIX 14 Supporting documents/websites

Cleaning instructions for home enteral feeding syringes (single patient use)

Enteral UK
http://www.gbukenteral.com/

BAPEN
http://www.bapen.org.uk/

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APPENDIX 14 Equality Analysis (Impact assessment)

Equality Analysis (Impact assessment)

1. What is being assessed?

| East Cheshire NHS Trust CNSG 006 Nasoenteral (nasogastric and nasojejunal) tube Insertion and Management for Adults |

Details of person responsible for completing the assessment:

- **Name**: Maggie Allen
- **Position**: Endoscopy Nurse Practitioner
- **Team/service**: Gastroenterology Department, Acute and Integrated Community Care Services on behalf of the Nutrition Steering Group.

State main purpose or aim of the policy, procedure, proposal, strategy or service:

(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

This policy is aimed at all employees of East Cheshire NHS Trust (ECT) and staff of other organisations who are working within the Trust, who have direct responsibility for the placement and management of nasogastric feeding tubes for adult patients:

- To promote a clear, consistent and evidenced based approach to the insertion, care and management of nasogastric tubes.
- To promote the safety and well-being of all patients who require a nasogastric tube.
- To provide guidance regarding scope of professional practice, level of competence and accountability in nasogastric tube insertion, care and management.
- To provide a framework for roles and responsibilities in nasogastric tube insertion and care thereafter.

This policy reflects the NPSA/NHS Improvement guidance (2005-2016) and National Institute for Clinical Excellence (NICE).

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it.

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

**Age**: East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.
Race:
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
- 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.

Gender: In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

Disability:
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender *(The Lesbian & Gay Foundation)*.
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2009 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% in 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
- **Christian:** 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- **Sikh:** 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- **Buddhist:** 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- **Hindu:** 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- **Jewish:** 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- **Muslim:** 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- **Other:** 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- **None:** 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
- **Not stated:** 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

Carers: In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)
No evidence of complaints

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?
Not aware of any issues

3. Assessment of Impact
Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

RACE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently? Yes  □  No  x
Explain your response: For any patient whose first language is not English, staff will follow the trust interpretation and translation policy to ensure that patients are able to give informed consent where they are able and to ensure that they have appropriate written information.

GENDER (INCLUDING TRANSGENDER):
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently? Yes  □  No  x
Explain your response: No impacts identified

DISABILITY
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently? Yes  □  No  x
Explain your response: For people with a disability, reasonable adjustments may need to be made to ensure that the patient/carer has access to relevant information. Information can be made available in a variety of formats including Audio and easy read by following the interpretation policy. There is a picture communication book in ward communication aids boxes. Reasonable adjustments such as pre-planning procedures, carer staying with patient for people with autism and/or learning disabilities. Reference is clear in the policy re dysphagia and aspiration issues and the process to follow. There is also clear detail on what to do if it is suspected that a patient lacks capacity.

AGE:
From the evidence available does the policy, procedure, proposal, strategy or service, affect, or have the potential to affect, age groups differently? Yes  □  No  x
Explain your response: No impacts identified

LESBIAN, GAY, BISEXUAL:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently? Yes  □  No  x
Explain your response: No impacts identified.
RELIGION/BELIEF:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently? Yes ☐ No x
Explain your response: Any cultural issues would be discussed with the patient and content of feed would be checked to ensure it is suitable for any religious requirements.

CARERS:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently? Yes ☐ No x
Explain your response: Carers would be involved in any explanations in order to support the patient

OTHER: EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently? Yes ☐ No x
Explain your response: No other impacts identified.

4. Safeguarding Assessment - CHILDREN
a. Is there a direct or indirect impact upon children? Yes ☐ No x
b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:
c. If no please describe why there is considered to be no impact / significant impact on children
This policy applies to adult patients only.

5. Relevant consultation
Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?
The following groups have been consulted for this policy: Nutrition Steering Group, Departments of Nutrition and Dietetics, Endoscopy, Radiology, Gastroenterology, Matrons and Nursing and Midwifery forum.

6. Date completed: Sept 2018 Review Date: July 2020

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
</thead>
</table>

8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead: Lyn Bailey

Date: 23.10.18
# APPENDIX 14  Policy / Procedure Approval Checklist

**Policy being approved:** East Cheshire NHS Trust CNSG 006 Nasoenteral (nasogastric and nasojejunal) tube Insertion and Management for Adults

**Date:** 25th September

**Reviewed by:** Maggie Allen

<table>
<thead>
<tr>
<th>Format/Content</th>
<th>Present in Policy</th>
<th>Comments (state if not applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arial Font</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Font size 11</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Trust logo on front page</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Title of policy on front page</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Policy control page completed</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Footer of each page details: name of policy, author and date of publication</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Numbered sequentially</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Policy statement present – containing the objectives of the policy</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Roles and responsibilities section present</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Implementation section present</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Appendices sections as appropriate</td>
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<td></td>
</tr>
<tr>
<td>Manager responsible identified</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Cross referenced to other documents as appropriate</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Impact assessment carried out</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Glossary included as appropriate</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>