# Fine Bore Nasogastric Feeding Tubes Policy
*(does not include Neonates)*

## Document Author

<table>
<thead>
<tr>
<th>Written By:</th>
<th>Clinical Nutrition Nurse Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>November 2019</td>
</tr>
</tbody>
</table>

## Authorised

<table>
<thead>
<tr>
<th>Authorised By:</th>
<th>Chief Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>21st February 2020</td>
</tr>
</tbody>
</table>

## Lead Director

| Director of Nursing, Midwifery, AHPs & Community Service |

## Effective Date

| 21st February 2020 |

## Review Date

| 20th February 2023 |

## Approval at

| Policy Management Sub-Committee |

## Date Approved

| 21st February 2020 |
NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>2. Introduction</td>
<td>4</td>
</tr>
<tr>
<td>3. Definitions</td>
<td>4</td>
</tr>
<tr>
<td>4. Scope</td>
<td>5</td>
</tr>
<tr>
<td>5. Purpose</td>
<td>5</td>
</tr>
<tr>
<td>6. Roles &amp; Responsibilities</td>
<td>6</td>
</tr>
<tr>
<td>7. Policy Detail / Course of Action</td>
<td>7</td>
</tr>
<tr>
<td>7.1 Indication</td>
<td>7</td>
</tr>
<tr>
<td>7.2 Consent</td>
<td>8</td>
</tr>
<tr>
<td>7.3 Contraindications</td>
<td>8</td>
</tr>
<tr>
<td>7.4 Insertion of NG tube</td>
<td>8</td>
</tr>
<tr>
<td>7.5 Confirm positioning newly inserted NGT</td>
<td>9</td>
</tr>
<tr>
<td>7.6 Documentation</td>
<td>9</td>
</tr>
<tr>
<td>7.7 Confirming correct position of NGT during on-going care</td>
<td>10</td>
</tr>
<tr>
<td>8. Consultation</td>
<td>10</td>
</tr>
<tr>
<td>9. Training</td>
<td>11</td>
</tr>
<tr>
<td>10. Monitoring Compliance and Effectiveness</td>
<td>11</td>
</tr>
<tr>
<td>11. Links to other Organisational Documents</td>
<td>11</td>
</tr>
<tr>
<td>12. References</td>
<td>12</td>
</tr>
<tr>
<td>13. Appendices</td>
<td>12</td>
</tr>
</tbody>
</table>
1 Executive Summary

This policy provides a clear consistent; evidence based approach to the safe placement of fine bore nasogastric tubes for feeding purposes, and is intended for inpatient settings only. This policy does not give guidance on the use of nasogastric tubes for aspiration although the principles of insertion are the same. The policy reflects all National Patient Safety Alerts and recommendations around nasogastric feeding to ensure that the care provided to patients within the Isle of Wight NHS Trust meet the standards of safe care expected.

This policy provides details on:
- Staff responsibilities in relation to the safe insertion and maintenance of fine bore nasogastric (NG) feeding tubes.
- Safe methods of checking placement of the NG tubes.
- Consultation of the policy during its development.
- Audit processes to ensure appropriate implementation.

Compliance with this policy will be monitored annually.

2 Introduction

Nasogastric tube feeding is common practice in the support of nutritionally compromised adults in hospital settings. Many tubes are inserted daily without incident. However, there is a small risk that the tube can become misplaced into the lungs during insertion, or move out of the stomach at a later stage.

Due to the evidence of harm all staff responsible for checking initial placement of nasogastric tubes (including staff who support carers/patients who check initial placement of tubes) must be aware that:
- a. NOTHING should be introduced down the tube before gastric placement has been confirmed
- b. DO NOT FLUSH the tube before gastric placement has been confirmed

Auscultation has historically been used to confirm correct nasogastric tube (NGT) placement. Recent studies of this method have shown it to be inaccurate. NG tubes should be aspirated and the tube position confirmed using pH indicator strips.

X–ray should not routinely be used and is viewed as only a second line test.

3 Definitions

1. **Nasogastric tube** – A Nasogastric tube (NGT) is a flexible tube that can be inserted trans nasally into the stomach. It is commonly used for delivery of feed, fluids, medication, or drainage of gastric contents (this policy does not cover NGTs used for drainage of stomach contents however the insertion techniques remain the same)

2. **Fine bore naso-gastric feeding tube**: Usually defined as between a 6 – 8fg (French gauge) size, NNNG (National Nurses Nutrition Group) guidelines state 6-12fg. The length of the tube is measured in centimetres (cms) starting at the distal tip (stomach end = “0” cms). Measurements are seen along the length of the tube, the tube length will vary depending on manufacturer. The tube should be radio opaque along its length, made of silicone or polyurethane which is passed through the nostril via the naso-pharynx into the oesophagus, then stomach.
3. Gastric Aspirate: Fluid obtained from the stomach via the NGT using an enteral syringe. Aspirate is then checked for pH using the recommended CE marked pH indicator testing strips.

4. CE marked pH paper - pH indicator paper is CE marked and intended by the manufacturer to test gastric aspirate. pH paper is more sensitive than litmus paper and must be used for confirming the position of the NG tube (NPSA 2005).

5. Enteral Syringes – purple syringes for enteral use only non IV compatible.

6. ‘NEX’ – is a measurement, in cms, taken from the Nose to Ear to Xyphoid process to estimate how far the nasogastric tube should be advanced on insertion.

4 Scope

This policy applies to all registered professionals inserting and/or maintaining fine bore nasogastric feeding tubes in Isle of Wight NHS Trust.

They are applicable to all patients, including paediatrics but with the exception of neonates.

This policy specifically relates to the use of nasogastric tubes for the purposes of feeding only, and does not cover the practice of using nasogastric tubes for drainage which is a practice specific to certain clinical areas who will have their own guidelines (e.g. intensive care unit or surgical wards). Staff should also be aware that nasogastric tubes should not be being used for both feeding and drainage at the same time, except in Intensive Care.

For administration of medication via a fine bore nasogastric feeding tube please refer to Medication policy and/or discuss with pharmacy. (See appendix H)

5 Purpose

This policy is designed to guide all Healthcare Professionals in the safe insertion and maintenance of fine bore nasogastric feeding tubes in adults and children excluding neonates.

- To promote a clear, consistent and evidenced based approach to the insertion, care and management of fine bore NGTs.

- To promote the safety and well-being of all patients who require an NGT for feeding

- To provide guidance regarding:-
  - scope of professional practice,
  - level of competence and
  - accountability in NGT insertion, care and management.

- To provide a framework for roles and responsibilities in nasogastric tube insertion and care thereafter.
6 Roles and Responsibilities

6.1 Chief Executive

The Chief Executive has accountability for the safe treatment and care of the organisation’s patients by its staff and contractors.

6.2 Clinical Directors

Directors are responsible for ensuring that sufficient resources are provided to support the requirements of this policy and that safety of patients and professional conduct is maintained.

6.3 Relevant Administrators/Senior Managers/Department Managers

Managers are responsible for ensuring that this policy is built into local processes, to ensure organisational compliance with national standards.
Ward sisters are responsible for ensuring that the policy standards are implemented in their clinical area where relevant to their ward’s practice.
Ward sisters must audit compliance with the policy standards for safe NG tube insertion and maintenance annually, and take relevant action where these standards are not maintained.

6.4 Medical Staff

The decision to commence artificial nutrition via a naso-gastric tube is a medical decision to be made in conjunction with the patient, the patients’ family and members of the multi-disciplinary team. It is the doctors responsibly to ensure the rationale for any decision is clearly documented within the healthcare records and include the assessment of the risks and benefits for that individual patient.

If the Healthcare Professional inserting the NGT is unable to confirm tube position at the bedside using pH testing of aspirate it is the doctors’ responsibility to request and review a chest X-ray to establish gastric placement once they have received the specific training to carry this out and are deemed competent by their professional clinical supervisor. (See Appendix F)

After 17.00hrs or at weekends and bank holidays the Registrar on-call should be asked to confirm the position of the NGT by interpreting the x-ray, if this task is delegated it is the Registrar’s responsibility to ensure the person they are delegating to has received the training and are competent to carry out this task.

Once the x-ray has been reviewed the documentation in the medical notes should state the following and all criteria should be met in order to correctly identify the NGT as being in the stomach:

1. That it is the most recent x-ray that has been reviewed for the correct patient
2. The NGT follows the oesophagus and avoids the contours of the bronchi
3. The NGT clearly bisects the carina
4. The NGT crosses the diaphragm in the midline
5. The NGT tip is clearly visible below the left hemi-diaphragm

It should be noted that the naso-gastric feeding tubes used in this trust are entirely radio opaque (not just the tip) without the guide-wire in situ.
6.5 Healthcare Professionals (Nursing staff & Doctors)

- Registered Nurses and/or Doctors are responsible for establishing the gastric placement of NGTs prior to their use and documenting their findings on the recognised Trust documentation.
- It is the responsibility of the Healthcare Professional to ensure they have received training and developed a level of competency as directed by the competency framework which is available on the Intranet.
- Only staff with the relevant skills and expertise should insert and confirm the placement of NG tubes.
- All staff that provide care to patients are responsible for ensuring they adhere to the principles described within this policy.
- Only staff with the relevant skills and expertise should undertake on-going placement checks prior to commencing feeding, flushing the tube or administration of medication.
- Assess patient comfort and safety through regular observation. An incident report must be completed where an incident related to the placement of NG tube occurs.

6.6 Clinical Nurse Specialists

The Clinical Nutrition Nurse Specialist is responsible for the development and review of this policy.

The Clinical Nurse Specialist is responsible for the management of this policy, and monitoring the effectiveness of its implementation as well as providing training sessions and assessing competencies for insertion and care when requested by the Ward Sister or individual Registered nurse.

The Clinical Nurse Specialist is available to assist staff with problematic NG placements and obtaining aspirate where staff have inappropriately requested chest X-rays. The Nutrition Nurse Specialist may also be involved with assessment for, and placement of Nasal Retaining Loops (Nasal 'Bridles') in those patients who repeatedly displace NGTs.

Where patients and/or relatives are required to manage these tubes in their own homes they are required to have undergone training to this effect and be assessed as competent by the registered nurse in the ward area. In the hospital setting it is expected that this will be documented and in place prior to discharge.

7 Policy detail/Course of Action

All staff need to be aware that the insertion of a fine bore nasogastric tube for feeding purposes is distinct from the use of nasogastric tubes, e.g. Ryles tubes, for the purpose of drainage. The use of nasogastric tubes for drainage is not covered by this policy and clinical areas who are using nasogastric tubes for this purpose should refer to the Marsden Manual for further guidance (Dougherty, 2015.)

7.1 Indication

Prior to passing a nasogastric feeding tube a risk assessment is required, balancing the potential risks of tube insertion against the need to feed. Actions to reduce risks and the rationale must be documented by the practitioner.

Nasogastric feeding can be used when the patient:
- Requires short term feeding
- Is malnourished
- Has a functioning Gastrointestinal tract
- Has been unable to fulfil their nutritional requirements orally for over 5 days
- Are not predicted to fulfil their nutritional requirements orally for over 5 days
- Have increased nutritional requirements e.g. sepsis, trauma, burns, post-op stress

Placement of the nasogastric tube should be delayed if there is not sufficient experienced support available to accurately place and confirm nasogastric tube placement (e.g. at night), unless clinically urgent. The rationale for any decisions made should be recorded in the patient’s medical notes.

The decision to insert a Nasogastric tube for the purpose of feeding must be made by a senior doctor responsible for the patient’s care after consultation with the patient and carers (if possible) and members of the multidisciplinary team.

### 7.2 Consent

The decision to consider use a NG feeding tube should be a multidisciplinary decision between the Consultant responsible for their care and the other healthcare professionals involved. The patient and their relatives/carers should also be involved in the decision making. The clinician’s decision and the reasons for this must be documented in the patient’s notes.

Although formal written consent is not required for minor procedures (DOH, 2009), verbal consent for the procedure should be obtained where possible and this should be documented in the patient’s notes.

If the patient lacks capacity around this decision then a best interest decision should be made. The practitioner must document in the patient’s notes how they came to the decision that the patient lacks capacity and why they believe the procedure to be in the patient’s best interest. There should be involvement from other healthcare professionals and family or carers in reaching that decision. Refer to Mental Capacity Act and deprivation of liberties.

### 7.3 Contraindications

The following are possible contra-indications for the insertion of a nasogastric feeding tube:

- maxillo-facial surgery, trauma or disease
- oesophageal tumours, strictures or surgery
- oesophageal/pharyngeal pouch or varices
- base of skull fracture
- unstable cervical spine
- haematological disorders

The contra-indications are not all absolute, but individual patients should be discussed with the medical team in charge of their care before a tube is passed. Some patients may require tubes placed using, endoscopic or radiological guidance.

### 7.4 Insertion of the NG feeding tube

The procedure for passing a nasogastric tube must be followed (See Appendix A).

If the tube meets resistance and cannot be advanced further or respiratory distress is evident, the procedure must be abandoned. The patient should be reassured and referral made to a senior member of the medical team who will review the situation and determine what action is necessary. This may include referral for assistance from the clinical nutrition nurse specialist. Out of hours, the responsible clinical team must risk assess further attempts
at insertion versus delay in provision of enteral nutrition, and any decisions documented in the medical notes.

7.5 Confirming position newly inserted NGT

The following are the only methods to be used to confirm position of NG feeding tubes after insertion as per the National Patient Safety Alerts. (Appendix A)

1. Aspiration and testing with pH indicator strips/paper which is CE marked and intended by the manufacturer to test human gastric aspirate is the preferred method to confirm tube position and is first line within the Trust. Isle of Wight NHS Trust use Johnson pH 2-9 strips which are available from NHS supplies. A pH of 5.5 or below is acceptable as indicating gastric placement in most patients. There is evidence to suggest that a pH reading of between 1 and 5.5, can reliably exclude pulmonary placement of the nasogastric tube. However, a pH between 1 and 5.5 does not necessarily confirm gastric placement of the nasogastric tube, and there is a small possibility that the tube is sitting in the oesophagus, which carries a higher risk of aspiration (NPSA). The procedure for confirming correct position of a nasogastric tube must be followed (see Decision trees appendix C & D). Medication may affect gastric acidity including Proton Pump Inhibitors, H2-antagonists and antacids, although the desired pH can usually be obtained. The pH of aspirate obtained on initial placement must be documented for future reference.

2. Radiography is recommended if after trying all methods it is still not possible to obtain gastric aspirate or the pH is greater than (> = 5.5 following insertion. The x-ray request form must be marked as being needed to confirm NG placement and the film reviewed as soon as possible. X-rays must be interpreted and nasogastric tube position confirmed by a healthcare professional assessed as competent to do so. If there is any difficulty in interpretation of the x-ray, the advice of a radiologist should be sought. Appropriate documentation must be made in medical notes before the NG tube is used.

A nasogastric tube identified to be in the lung must be removed immediately, whether in the radiology department or clinical area.

Note an x-ray only confirms the position at the time the image was taken.

The correct position of the nasogastric tube must be confirmed following insertion and documented before feeding is commenced. Nothing should be introduced down the tube before gastric placement is confirmed i.e. do not flush. (see appendix G)

Methods not to be used to confirm position

Auscultation of the epigastrium or left upper quadrant whilst air is insufflated via the tube was historically used. This method is not able to reliably predict tube placement in the oesophagus, stomach or respiratory tract and must not be used. (NPSA 2005, 2011)

Aspiration and testing with blue litmus paper was previously used. Although acidic gastric secretions will turn blue litmus paper pink, litmus is not sufficiently accurate to distinguish between gastric aspirate pH ≤ 5.5 and bronchial secretions pH > 6 and therefore must not be used.
7.6 Documentation

Accurate documentation within the clinical records and at the bedside in the care plan must be made (see Appendix E). Below is the minimum requirement:

- Clinical reason for the NG tube
- What consent was obtained i.e. verbal consent or best interest decision
- NEX measurement
- Actual length at the nostril
- pH result (two staff to check on initial insertion and sign)
- If an x-ray is needed the following 5 points must be documented:
  1. That it is the most recent x-ray that has been reviewed for the correct patient
  2. The NGT follows the oesophagus and avoids the contours of the bronchi
  3. The NGT clearly bisects the carina
  4. The NGT crosses the diaphragm in the midline
  5. The NGT tip is clearly visible below the left hemi-diaphragm

There is a sticker in the NG tube pack which if completed details all these elements (see appendix G)

7.7 Confirming correct position NGT during on-going care

The correct position of the nasogastric tube must also be confirmed:
- before commencing each feed or after rest periods
- following vomiting, violent coughing or retching episodes
- at least once during continuous 24 hour feeding
- following evidence of tube displacement (change in external length, loose tape etc.)

The pH must then be documented before feed, fluids or medication is introduced into the tube.

Radiography should not be used for routine daily confirmation of tube position due to increased exposure to radiation, impracticality, costs and disruptions to feeding.

pH of gastric contents should be used as above (Appendix B & Decision Trees Appendix C & D)

Clinical judgement and expertise should also be used when deciding if the tube is correctly positioned, particularly when the correct pH cannot be obtained, and any judgements made must be documented.

An individual risk assessment must be carried out for each patient. For example, if the pH is constantly higher than 5.5 on each occasion the tube is aspirated, but on x-ray the tube is found to be correctly positioned, then it could be accepted that for this patient a pH of >5.5 is ‘normal’ and feeding can continue. This must be clearly documented.

If in any doubt a chest x-ray may be needed.

8 Consultation

The following staff groups have been consulted on regarding the development of this document.

- Ward sisters
- Modern Matrons
- Paediatrics
- Critical Care Outreach Service
- Dietetics Department
Changes within the policy are based on response from these key professionals.

9 Training

It is expected that fine bore naso-gastric tubes will be inserted by Registered Nurses or Doctors who have been deemed competent in this procedure. Registered professionals have a responsibility not to undertake this procedure without supervision if they do not feel competent to do so.

It is expected that registered professionals required to undertake this task as part of their day to day work access formal training sessions for this purpose provided by the clinical nutrition nurse specialist. To develop competency they may work with other registered professionals trained and competent in the safe insertion of fine bore nasogastric tubes. A formal assessment of competence must be signed off at the end of this process.

Care and maintenance will be provided by a registered nurse who has been deemed competent.

Ward sisters and medical leads are responsible for ensuring staff are released for training and complete competency to required level.

Clinical nutrition nurse specialist to maintain a high profile in clinical areas to support implementation of this policy.

Clinical nutrition nurse specialist to provide training to nursing staff as required by individual ward areas and/or individuals

This does not have a mandatory training requirement but non-mandatory training provided by clinical nutrition nurse specialist is highly recommended in order to establish a base line for competency.

10 Monitoring Compliance and Effectiveness

Overall responsibility for monitoring effectiveness of this policy resides with the clinical nutrition nurse specialist. Overall responsibility for monitoring compliance resides with Modern Matrons and Ward Sisters.

Ward Sisters and Modern Matrons are to ensure staff are aware of Policy and that it is adhered to at ward level.

Audits will be undertaken twice a year by the clinical nutrition nurse to ensure compliance with the policy is maintained and these will be monitored through each of the clinical care groups.

Ward sisters will be responsible for developing action plans if their ward fails to comply with this policy and manage staff appropriately.

Training records will be held on the Trust Learning Management System to ensure there is a central record of staff that have been assessed as being competent in the insertion of NG feeding tubes.
Clinical nutrition nurse specialist will receive any incident forms related to problems with NG feeding tubes, monitor these for themes and action them as needed.

11 Links to other Organisational Documents

- Guideline for the insertion and management of a naso-gastric tube retention device ‘Corgrip’
- Medicines Policy
- Consent to Examination or Treatment policy
- Standard Infection Control Procedures
- Hand Hygiene Policy
- Safe Disposal of Clinical Waste
- Nutrition Policy to Prevent & Manage Malnutrition in Adults
- Mental Capacity Act / Deprivation of Liberties

12 References


13 Appendices

Appendix A – Guidelines: Fine bore nasogastric tube feeding insertion
Appendix B – Guidelines: Fine bore nasogastric tube feeding on-going care
Appendix C – Decision tree for nasogastric tube placement checks in ADULTS
Appendix D – Decision tree for nasogastric tube placement checks in CHILDREN
Appendix E – Nutrition care plan (Nasogastric tube feeding)
Appendix F – X-ray interpretation aid
Appendix G – Example of sticker within the NG tube.
Appendix H - Administering Drugs via Enteral Feeding Tubes a Practical Guide
Appendix I – Financial and Resourcing Impact Assessment on Policy Implementation
Appendix J - Equality Impact Assessment (EIA) Screening Tool
Appendix A

Guidelines for Clinical Practice
Fine bore nasogastric tube feeding insertion.

Prior to Insertion:

Check:
- That there has been a documented multi-disciplinary decision taken to nutritionally support the patient
- That the patient and relative/carer have been included in the decision-making. Where Mental Capacity is in doubt, then clearly documented actions have been taken to address these issues.
- That there is a feeding regime prescribed by the Dietician
- The local policy for checking correct positioning of the tube.

NG tube feeding is suitable for patients who:
- Require short term feeding
- Are malnourished
- Have a functioning GI tract
- Have been unable to fulfil their nutritional requirements orally for over 5 days
- Are not predicted to fulfil their nutritional requirements orally for over 5 days
- Have increased nutritional requirements e.g. sepsis, trauma, burns, post-op stress

Contraindications
- NG feeding tube placement should not be considered in the following patients:
  - Maxillo – facial disorders, surgery or trauma
  - Oesophageal tumours or surgery
  - Laryngectomy
  - Patients who have had oro-pharyngeal tumours or oro-pharyngeal surgery
  - Skull fractures
  - Nasal C.P.A.P
  - Unstable cervical spinal injuries (involving vertebrae 4 or above)
  - Oesophageal varices

The following patients are at increased risk of tube misplacement:
- Sedated patients.
- Endotracheal intubated patient
- Agitated patients
- Patients with a weak cough reflex

Procedure for passing a nasogastric feeding tube and confirming correct position on insertion

Equipment
- Fine bore feeding tube of appropriate size
- pH indicator paper
- Nose plaster or appropriate tape/scissors
- Non-sterile gloves
- Apron
- 60 ml purple enteral syringe
- Glass of water/straw (if appropriate)
- Tissues
- Receiver
- An assistant

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain procedure to patient. Agree a signal to indicate a problem or stop the procedure.</td>
<td>To obtain patients consent and co-operation.</td>
</tr>
<tr>
<td>Ensure universal precautions are used at all times</td>
<td>To adhere to local infection control</td>
</tr>
<tr>
<td>Estimate the length of the tube by measuring using NEX (Nose, Ear, Xiphisternum), placing external port at nose, extend to earlobe and note external mark at xiphisternum.</td>
<td>To ascertain an appropriate measurement to ensure tube is sited at correct length.</td>
</tr>
</tbody>
</table>
| a) Ideally where possible the patient should be sitting in a semi-upright position supported with pillows  
   b) For the semi-conscious patient it is often easier to be in a lying position on their side. | To increase patient comfort and facilitate easier insertion of the tube and avoid inadvertent tracheal intubation. This position allows easy swallowing and ensures that the epiglottis is not obstructing the oesophagus. |
| Clean hands and apply gloves. Assemble required equipment, select appropriate tube. | To ensure a clean procedure is maintained throughout. Consider fg size of NGT required depending on diagnosis |
| Check nose and mouth for any signs of obstruction and ensure both are clean. | To aid passage of NGT |
| Check nasal patency by sniff with each nostril occluded in turn. | Patient may have one nostril which is clearer than the other e.g. deviated nasal septum. |
| Gently stretch the tube and lubricate the tube as per manufacturer’s instructions | This will ensure that the guide wire can be easily removed once placed in patient. DO NOT lubricate the inner lumen of the tube with water before insertion and checking gastric positioning. DO NOT USE STERILE WATER AS THIS HAS pH OF 5.5 |
| Insert the tube into the clearest nostril and slide backwards and inwards along the floor of the nose to the nasopharynx approx. 10-12cm and STOP  
   If any obstruction is felt withdraw tube slightly and try again at a slightly different angle.  
   a) If the patient can swallow coincide passing NGT with swallowing a sip of water  
   b) If the patient is dysphagic but can swallow own secretions – encourage a dry swallow  
   Slowly advance the tube to the pre-determined mark. | There are two distinct stages when passing the tube.  
   a) Nose → pharynx → stop and swallow  
   b) Pharynx → stomach.  
   The passing of the NGT can be coordinated with observing for laryngeal movement. During this phase the epiglottis covers the airway and NGT can pass into oesophagus.  
   To facilitate the passing of the tube. Risk of aspiration. |
Where the patient is unable to swallow fluid, wait for the peak of expiration before slowly advancing the tube to the pre-determined mark. NB: A chin towards chest position may aid insertion if patient is able. This reduces the risk of aspirating fluids. May facilitate tube advancement

<table>
<thead>
<tr>
<th>If you are unsuccessful repeat above procedure in other nostril. Consider smaller bore and/or weighted tube. Do not repeat procedure more than 3 times. Seek advice from another healthcare professional or contact nutrition nurse.</th>
<th>One nostril may be clearer than the other. Smaller gauge or weighted tube may be easier to pass on specific patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once at appropriate measurement secure nasogastric tube in place using hypafix/biocclusive across side of face or ‘grip-lok’. Do not apply to nose.</td>
<td>Securing to cheek reduces the risk of nasal pressure injury and promotes comfort as out of patient’s line of vision NNG guidelines advise that the guidewire should remain in situ until after confirmation of correct placement as this will aid readjustment of position if required. Most fine bore NGTs are radio-opaque and do not require the guide wire to be insitu for X-ray. <strong>Under no circumstances</strong> should the guide-wire be reinserted into the tube whilst the tube remains in the patient. Do not leave the guide wire in for long periods as it is uncomfortable for the patient. This will provide an easily identifiable mark as a baseline</td>
</tr>
<tr>
<td>Do not remove the guide wire at this stage</td>
<td></td>
</tr>
<tr>
<td>Document visual external mark in the careplan for comparison.</td>
<td></td>
</tr>
<tr>
<td>Follow steps a-c below to obtain aspirate and verify correct NGT position.</td>
<td>This is the first line test for NGT position</td>
</tr>
<tr>
<td>a) Using a 50ml enteral syringe insufflate up to 10-20ml of air via NGT.</td>
<td>This clears tube of debris and forces the end of the tube away from the stomach mucosa. The pH of aspirate should be measured using CE marked pH indicator strips in the range 0-6 with ½ point gradations. Litmus strips must not be used as it does not indicate the degree of acidity. A pH of 5.5 and below (acid) indicates gastric placement. pH reading <strong>MUST</strong> be 5.5 or below.</td>
</tr>
<tr>
<td>b) Attempt to gain aspirate from NGT (0.5-1ml minimum) by gently withdrawing plunger on syringe. If aspirate is obtained - check using pH indicator strips.</td>
<td></td>
</tr>
<tr>
<td>c) If pH is 5.5 or below (NPSA recommends second checker), guide wire may be removed, 10mls water can be passed down tube at this stage as position is confirmed to aid removal of guidewire, &amp; tube maybe used. X-ray is not required.</td>
<td></td>
</tr>
<tr>
<td>If unable to obtain aspirate, refer to NPSA decision tree (Appendix B &amp; C):</td>
<td>Tip of tube may not be in fluid pool in the stomach- advancing tube should enable aspirate to be obtained as tip of tube should be in gastric fluid pool. Withdrawing tube should allow aspirate to be obtained-by putting tip of</td>
</tr>
<tr>
<td>a) Turn patient onto left side, wait 15-30 minutes before aspirating again.</td>
<td></td>
</tr>
</tbody>
</table>
c) Give mouth care to patients who are nil by mouth to stimulate gastric secretions.

d) Consider any medications that the patient may be taking:

Prokinetics e.g. Metoclopramide
PPIs e.g. Lansoprazole

tube in gastric fluid pool. To change the fluid level in the stomach - as this may enable aspirate to be obtained. May increase stomach emptying making it difficult to obtain aspirate. Will elevate the pH - unlikely to obtain an acid aspirate.

| In the absence of a positive aspirate test (or pH of 5.5 and below) contact the medical team for an X-ray |
| NB Confirmation of tube position by X-ray is only correct at the time of X-ray. Subsequent checking of position by aspirate test must be carried out at the bedside. See below. |

| On initial insertion X-ray will provide confirmation of position and a baseline from which to base on-going clinical judgments on whether the NG is safe to use. |

| Following insertion and confirmation of correct position, document procedure in medical and nursing notes – including pH of aspirate obtained +/- confirmation by X-ray, and measurement of tube at nose. Position of tube on X-ray must be confirmed by a doctor and be documented in medical notes prior to use of NG. Use the Trust care plan (appendix D). |

| Accountability for checking the tube position before use lies with the competent Healthcare Professional. Recording the procedure is a requirement in law and provides a baseline for further measurement. This is a legal requirement |

| At the end of the procedure the staff member: removes gloves, cleans their hands, and disposes of waste as per Trust policy. |

| Implement NG tube checking chart (Appendix D) at bedside as found on the back of the care plan. |

| To ensure documentation of NG position is checked |

**Methods that MUST NOT be used to check position:**

- Auscultation of air insufflated through the feeding tube (‘whoosh’ test);
- Testing the acidity/alkalinity of aspirate using blue 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.

For more information about the safety issues involved, or for details of references used, please see [www.npsa.nhs.uk/advice](http://www.npsa.nhs.uk/advice)
Appendix B

Guidelines for Clinical Practice.
Fine bore nasogastric tube feeding on-going care

Important points to remember:

- Before commencing the feed and/or give medication, check that the tube is still in the correct position (A CHECK SHOULD BE MADE AT LEAST DAILY).
- If the patient vomits, retches violently or has a severe bout of coughing re-check the position of the tube.
- Whilst the patient is receiving the feed and for approximately one hour post-feed the patient should be propped up at an angle of 45°.
- Wash hands before handling any equipment or feed products.
- Always ensure that the tube is flushed with freshly drawn water before, during and after feeding, before and after administering each medication and if the pump needs to be switched off (THE TUBE WILL BLOCK VERY QUICKLY IF FEED IS LEFT IN THE LUMEN).
- Be aware of the BAPEN guidelines on administration of medication via feeding tubes.
- Change all equipment i.e. syringes, administration sets every 24 hours.
- Ensure the pump is kept clean and in working order.
- Maintain records of intake/output.
- Patient should be weighed weekly.
- If diarrhoea occurs reduce the rate of the feed and refer back to the Dietician.
- Having a feeding tube in situ does not preclude the patient from eating and drinking if there is no contraindication to this (i.e. swallowing difficulties).
- All staff must report misplaced feeding tube incidents through their local risk management systems.

The recommended procedure for on-going checking the position of nasogastric feeding tubes in infants, children and adults

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check whether the patient is on medication that may increase the pH level of gastric contents.</td>
<td>Medications that could elevate the pH level of gastric contents are antacids, H2 antagonists and proton pump inhibitors. For those patients who are regularly on antacids, the initial risk assessment needs to identify actions that staff should take in this scenario and document them in the care plan. The initial pH of the aspirate should also be documented in the case notes.</td>
</tr>
<tr>
<td>Check for signs of tube displacement.</td>
<td>Documenting the external length of the tube initially and checking external markings prior to feeding will help to determine if the tube has moved. The documentation will also assist radiographers if an x-ray is needed.</td>
</tr>
<tr>
<td>Sufficient aspirate (0.5 to 1ml) obtained.</td>
<td>0.5 to 1ml aspirate will cover an adequate area on the single, double or triple reagent panels of pH testing strips/paper. Allow ten seconds for any colour change to occur.</td>
</tr>
<tr>
<td>Aspirate is pH 5.5 or below.</td>
<td>Commence feed. There are no known reports of pulmonary aspirates at or below this figure. The range of pH to 5.5 balances the risk between increasing the potential problems for clinical staff e.g. removing tubes that are actually in the stomach, increased use of x-ray, with the as yet, unreported possibility of feeding at pH 5.5 when the tube is in the respiratory tract.</td>
</tr>
</tbody>
</table>
Aspirate is pH 6 or above. **DO NOT FEED.** Possible bronchial secretion; leave for up to one hour and try again. The initial risk assessment should identify actions for staff to take in this scenario for each patient. The actions should be documented in the care plan and/or in local policies.

If there is ANY doubt about the position and/or the clarity of the colour change on the pH indicator strip/paper, particularly between the ranges pH 5 and 6, then feeding should NOT commence – seek advice.

Wait up to one hour before re-aspirating to check pH level. The most likely reason for failure to obtain gastric aspirate below pH of 5.5 is the dilution of gastric acid by enteral feed. Waiting for up to an hour will depend on the clinical need of the patient and whether or not they are on continuous or bolus feeds.

### Problems obtaining aspirate?

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turn patient onto their side.</td>
<td>This will allow the tip of the nasogastric tube to enter the gastric fluid pool.</td>
</tr>
<tr>
<td>Inject air (1-5ml for infants and children, 10-20ml for adults) using 20ml or 50ml syringe. Wait for 15-30 minutes and try again.</td>
<td>Injecting air through the tube will dispel any residual fluid (feed, water or medicine) and may also dislodge the exit-port of the nasogastric feeding tube from the gastric mucosa. Using a large syringe allows gentle pressure and suction; smaller syringes may produce too much pressure and split the tube (check manufacturers guidelines). Polyurethane syringes are preferable to other syringes. It is safe practice to use nasogastric tubes and enteral syringes that have non luer connectors</td>
</tr>
<tr>
<td>Advance the tube by 1-2cm for infants and children or 10-20cm for adults.</td>
<td>Advancing the tube may allow it to pass into the stomach if it is in the oesophagus.</td>
</tr>
<tr>
<td>Consider x-ray</td>
<td>X-ray should not be used routinely. The radiographer will need to know that this advice has been followed, what the problem has been and the reason for the request. The radiographer should document this. Fully radio-opaque tubes with markings to enable measurement, identification and documentation of their external length should be used.</td>
</tr>
<tr>
<td>Additional tip</td>
<td>If the patient is alert, has intact swallow and is perhaps only on supplementary feeding and is thus eating and drinking during the day, ask them to sip a coloured drink and aspirate the tube. If you get the coloured fluid back then you know the tube is in the stomach.</td>
</tr>
</tbody>
</table>

### Other considerations:

**Patient comfort:**
- Previous injury, blocked nose
- Sensitivity to tape
- Reduce irritation of tube ‘flopping’ round
- Does the patient wear glasses

**Mouth & nasal care:**
- Regular mouth care as per hospital policy
- Sensitivity in nostrils, sneezing, hay fever
- Avoid rubbing or excessively blowing nose as may dislodge tube

**Body image:**
- Discuss with patient and family
- Provide privacy if required

**Timing of feeds:**
- Dependent on patient tolerance initially – more flexibility later
- If patient to be discharged with enteral feeding it is best to establish early regime
- Consider timing of activities such as physiotherapy
- Patient medication (certain drugs interact with feed)

**Bowels:**
- Alert patient to possible changes in bowel habit
- Provide easy access to toilet facilities
- Monitor frequency and consistency of bowels
- Be aware of constipation

**Dehydration:**
Although fluid requirements are carefully calculated by the Dietician there are several things that may result in the patient becoming dehydrated:
- Commencement of Diuretics
- Diarrhoea and/or vomiting
- Excessive perspiration – particularly in the summer months

**Medication:**
- Most drugs are not licensed to be given via enteral feed tubes
- SEEK ADVICE FROM PHARMACY IF UNSURE OR WHERE NECESSARY
- See also BAPEN leaflet (Appendix E)

**Carers/relatives:**
- Involve as much as possible, particularly if the patient is to be discharged with tube
- Check competency of carers with relation to the tube feeding before discharge
- Ensure support services are in place before discharge i.e. Hospital at Home, District Nurse, contact numbers for Dietician and Nutrition Nurse
Decision tree for nasogastric tube placement checks in **ADULTS**

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

**Aspirate obtained?**

**YES**

Try each of these techniques to help gain aspirate:
- If possible, turn adult onto left side.
- Inject 10-20ml air into the tube using a 50ml syringe.
- Wait for 15-30 minutes before aspirating again.
- Advance or withdraw tube by 1-20cm.
- Give mouth care to patients who are nil by mouth (stimulates gastric secretion of acid).
- Do not use water to flush.

Test aspirate on CE marked pH indicator paper for use on human gastric aspirate.

**pH between 1 and 5.5**

**pH NOT between 1 and 5.5**

**PROCEED TO FEED or USE TUBE**

Record result in notes and subsequently on bedside documentation before each feed/medication/flush.

**Aspirate obtained?**

**YES**

Proceed to x-ray: ensure reason for x-ray documented on request form.

Competent clinician (with evidence of training) to document confirmation of nasogastric tube position in stomach.

**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 or retests.

---

www.npsa.nhs.uk/alerts
**Decision tree for nasogastric tube placement checks in CHILDREN and INFANTS (NOT NEONATES)**

- Estimate NEX measurement (Place exit port of tube at tip of nose. Extend tube to earlobe, and then to xiphisternum)
- Insert fully radio-opaque nasogastric tube for feeding (follow manufacturer’s instructions for insertion)
- 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 child/infant onto left side
- Inject 1-5ml air into the tube using a syringe
- Wait for 15-30 minutes before aspirating again
- Advance or withdraw tube by 1-2cm.
- Give mouth care to patients who are nil by mouth (stimulates gastric secretion of acid)
- Do not use water to flush

**Aspirate obtained?**

**NO**

Test aspirate on CE marked pH indicator paper for use on human gastric aspirate

**pH between 1 and 5.5**

- **YES**
  - PROCEED TO FEED or USE TUBE
    - Record result in notes and subsequently on bedside documentation before each feed/medication/flush.
  - **YES**
    - Consider re-siting tube or call for senior advice

- **NO**
  - **NO**
    - Competent clinician (with evidence of training) to document confirmation of nasogastric tube position in stomach
    - **NO**
      - DO NOT FEED or USE TUBE

**pH NOT between 1 and 5.5**

- **YES**
  - Proceed to x-ray: ensure reason for x-ray documented on request form

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 or retests.

www.npsa.nhs.uk/alerts
NUTRITIONAL CARE PLAN V for use with adult patients V 0.1  
(Pilot as prepared for Health Records Committee)

Name …………………………………………
ADDRESSOGRAPH
IW No …………………………………………

<table>
<thead>
<tr>
<th>Date Commenced</th>
<th>Ward</th>
<th>Consultant</th>
</tr>
</thead>
</table>

**NEED / PROBLEM**

______________________________ is unable to take oral nutrition and has a nasogastric tube in situ for feeding and hydration.

**GOAL**

Aim to provide adequate nutritional intake and hydration via nasogastric tube in a safe and comfortable manner.

**ASSESSMENT PHASE**

<table>
<thead>
<tr>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Discuss with patient and relatives the need for nasogastric tube and explain the procedure fully.</td>
</tr>
<tr>
<td>2. If enteral feeding is required because the patient has a swallow impairment, ensure a referral is made to Speech &amp; Language therapist.</td>
</tr>
</tbody>
</table>

**MANAGEMENT PHASE**

<table>
<thead>
<tr>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Insert tube as per recognised procedure in accordance with the Organisations guidelines and tape securely and comfortably.</td>
</tr>
<tr>
<td>2. Check the position of the tube by testing with pH indicator paper.</td>
</tr>
<tr>
<td>3. Reconfirm the tube position at least daily before the feed commences and before giving medication</td>
</tr>
<tr>
<td>4. Aspirate from the fine bore Naso-gastric feeding tubes must register on the pH level as below 5.5. Anything greater than this must be discussed with a doctor.</td>
</tr>
<tr>
<td>5. Flush tube with water before and after every feed as directed by dietician – also before/after medication and between each medication</td>
</tr>
<tr>
<td>6. Refer patient to dietician for feeding regimen</td>
</tr>
<tr>
<td>7. Offer constant reassurance to patient</td>
</tr>
<tr>
<td>8. Offer regular anti-emetics if prescribed</td>
</tr>
<tr>
<td>9. Offer regular mouth care</td>
</tr>
<tr>
<td>10. Administer prescribed feeds at room temperature</td>
</tr>
<tr>
<td>11. Administer feeds via regulating device</td>
</tr>
<tr>
<td>12. If possible, aim to educate patient and/or carer to administer own feeds</td>
</tr>
<tr>
<td>13. Weigh patient regularly (recommended weekly) &amp; using MUST screening tool reassess patients nutritional status</td>
</tr>
<tr>
<td>14. If patient should vomit or develop diarrhoea, please advise the dietician</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date &amp; time of insertion</th>
<th>Type/size of tube (e.g. Corflo 8 fr)</th>
<th>Inserted to (cms) (as marked on tube)</th>
<th>pH of aspirate</th>
<th>Signature</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date &amp; time of insertion</th>
<th>Type/size of tube (e.g. Corflo 8 fr)</th>
<th>Inserted to (cms) (as marked on tube)</th>
<th>pH of aspirate</th>
<th>Signature</th>
</tr>
</thead>
</table>

Fine Bore Nasogastric Feeding Tubes Policy  
(Excluding Neonates)  
Version No. 3.0
## Ongoing Review Notes

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Detail (including progress / changes in condition)</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NB: Tube position <strong>MUST</strong> be checked by aspiration at least daily</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aspirate pH</th>
<th>Distance mark (cm)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Nasogastric tubes: X-ray interpretation aid

To confirm gastric position of the nasogastric tube, ask:

- Does the tube path follow the oesophagus/avoid the contours of the bronchi?
- Does the tube clearly bisect the carina or the bronchi?
- Does it cross the diaphragm in the midline?
- Is the tip clearly visible below the left hemidiaphragm?

Proceed to feed only if all criteria are met. If in any doubt repeat 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 shows the tip of the nasogastric tube above the diaphragm and on the right-hand side of the thorax. The presence of ECG leads make interpretation of the radiograph more difficult.

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.
ADMINISTERING DRUGS VIA ENTERAL FEEDING TUBES
A PRACTICAL GUIDE

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

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

WHICH TYPE OF WATER?
- Check local policy
- The type of water recommended depends on local practice and the exit site of the tube.

SYRINGE TYPE AND SIZE?
- 50ml oral, enteral or catheter tipped syringes should be used.
- It may be necessary to use a specially designed connector.
- A smaller syringe may produce too much pressure and split the tube (check manufacturer's guidelines).
- Do not use syringes intended for intravenous use due to the risk of accidental parenteral administration.

INFECTION CONTROL AND SAFETY
- Wash hands and wear gloves.
- It is important that exposure to drug powder is kept to a minimum.

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

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

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

STOP THE FEED
Flush the tube with at least 30ml of water.

Do you need to allow a break before administering the medicine?

Assemble medication and equipment needed e.g. syringes, pestle and mortar.
Prepare each drug separately.
Never mix drugs unless instructed by a pharmacist.

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

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

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

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

(RE-START THE FEED)
For further advice contact your local hospital Medicines Information Department.

Sponsored by Educational Grant from Ralls Ltd, Prensiva Ltd, Merck, Gastrostomy, Nutricia, Clinical Care, Bassetom Pharmaceuticals Ltd, Tyco Health Care.
Appendix I

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

<table>
<thead>
<tr>
<th>Document title</th>
<th>Fine bore Nasogastric Feeding Tubes Policy (excluding Neonates)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Totals</th>
<th>WTE</th>
<th>Recurring £</th>
<th>Non-Recurring £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manpower Costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Training Staff</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Equipment &amp; Provision of resources</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Summary of Impact: Failure to support implementation of this policy will be contrary to Patient Safety Federation guidelines

Risk Management Issues: Patient Safety

Benefits / Savings to the organisation: Reduce risk of harm to patients

Equality Impact Assessment

- Has this been appropriately carried out? YES/NO
- Are there any reported equality issues? YES/NO

If “YES” please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

<table>
<thead>
<tr>
<th>Manpower</th>
<th>WTE</th>
<th>Recurring £</th>
<th>Non-Recurring £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational running costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Totals: 0 0 0
### Staff Training Impact

<table>
<thead>
<tr>
<th></th>
<th>Recurring £</th>
<th>Non-Recurring £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Equipment and Provision of Resources

<table>
<thead>
<tr>
<th></th>
<th>Recurring £ *</th>
<th>Non-Recurring £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation / facilities needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building alterations (extensions/new)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IT Hardware / software / licences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stationery / publicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilities e.g. telephones</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rolling replacement of equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment maintenance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marketing – booklets/posters/handouts, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:

Signature & date of financial accountant:

Funding / costs have been agreed and are in place:

Signature of appropriate Executive or Associate Director:
### Equality Impact Assessment (EIA) Screening Tool

<table>
<thead>
<tr>
<th>Document Title:</th>
<th>Fine Bore Nasogastric Feeding Tube Policy (excluding Neonates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of document</td>
<td>To outline how patients receiving nasogastric feeds should be care for in line with national patient safety guidelines</td>
</tr>
<tr>
<td>Target Audience</td>
<td>All Trust Staff responsible for the insertion or care of those receiving enteral feeding via a nasogastric feeding tube</td>
</tr>
<tr>
<td>Person or Committee undertaken the Equality Impact Assessment</td>
<td>Clinical Nutrition Nurse Specialist</td>
</tr>
</tbody>
</table>

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

   If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

   If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Asian British People</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Black or Black British People</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Chinese people</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>People of Mixed Race</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>White people (including Irish people)</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
3. Level of Impact

If you have indicated that there is a negative impact, is that impact:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal (it is not discriminatory under anti-discriminatory law)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intended</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:

3.2 Could you improve the strategy, function or policy positive impact? Explain how below:

3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or
improves relations – could it be adapted so it does? How? If not why not?

<table>
<thead>
<tr>
<th>Scheduled for Full Impact Assessment</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of persons/group completing the full assessment</td>
<td></td>
</tr>
<tr>
<td>Date Initial Screening completed</td>
<td></td>
</tr>
</tbody>
</table>