

Guideline for the Safe Insertion of Fine Bore Nasogastric Feeding Tubes for Young People Requiring Enteral Feeding as Part of the Eating Disorder Pathway (CAMHS Inpatient Unit)

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VALIDITY – Guidelines should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
1.0	Oct 2019	New guideline
1.1	Jan 2020	Minor amendment regarding tube displacement on page 11
1.1	Oct 2020	No changes required
1.2	Dec 2022	Updated guidance to MEED, training and competency framework and linked to new standard operating procedures/ guidelines. Additional details added regarding consent and capacity. Approved at Physical Health and Medical Devices Group (14/12/22).

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1. INTRODUCTION

In exceptional circumstances during the care and treatment of young people with an eating disorder it may be necessary to consider and instigate a period of enteral feeding by nasogastric tube to prevent extreme weight loss and cardiovascular collapse.

This guideline aims to provide a framework for required actions at an operational level in order to facilitate the implementation of this feeding when clinically required.

The standards set out within this guideline reflect best practice as defined by the National Patient Safety Agency (NPSA) and NICE.

Introducing fluids or medication into the respiratory tract or pleura via a misplaced nasogastric tube is a Never Event [Never-Events](#). Therefore, it is imperative that staff follow best practice guidance and receive training and competency assessment

The aim of this guidance is to:

- Provide guidance on the insertion and subsequent management of enteral feeding tubes ensuring it is safe, effective and comfortable for the young person.
- Provide clear direction for the procedure for checking the safe position of a nasogastric tube in accordance with several patient safety alerts.
- Describes the training requirements for any staff who are expected to undertake this procedure as part of their defined role.

2. SCOPE OF THE GUIDELINE

This guideline applies to all employees of Humber Teaching NHS Foundation Trust and staff of other organisations who are working within the CAMHS unit, who have direct responsibility for the placement and management of enteral feeding tubes and for the administration of enteral feeds.

This guideline should be read in conjunction with the overarching 'Nutrition Guideline for the CAMHS inpatient which outlines the general principles of nutrition and hydration within our CAMHS inpatient service and also makes reference to nasogastric feeding and refeeding syndrome. In addition, this guideline should be read in conjunction with the Eating Disorder Standard Operating Procedure to guide safe patient care for young people presenting with Eating Disorders at Inspire and the CAMHS Safety Pod Standard Operating Procedure.

3. DEFINITION OF ENTERAL FEEDING

The term enteral tube feeding describes the delivery of nutrition into an individual's gastro-intestinal tract via a tube type device. A primary example of this would be nasogastric tubes (NGT).

This guideline refers only to the insertion of a fine-bore nasogastric feeding tube when feeding young people who continually refuse oral intake of food as this is the only method of enteral feeding that is used within the unit.

4. ROLES AND RESPONSIBILITIES IN THE PROVISION OF ENTERAL FEEDING

All employees involved in the practice of enteral feeding are responsible for ensuring that they are competent in the procedures identified and deliver practice to the **trust** standards and as such in line with best practice.

Medical Lead

Although the decision to commence artificial nutrition via a nasogastric tube will be taken in consultation with the young person, the family when appropriate and the multi-disciplinary team the Consultant in charge of the patient's care is ultimately responsible for ensuring the co-ordination of the nutritional, medical and psychological interventions requirements are met. This includes the monitoring the individual's clinical condition. It is paramount that the lead is responsible for working in partnership with colleagues in the acute trust to ensure the safe transfer and optimal transition of any young person who is requiring transferring from one service to another due to a change or deterioration in clinical condition.

They are responsible for:

- Deciding in liaison with the multi-disciplinary team on the optimal approach to each patient's nutritional needs and ensuring informed consent/second opinion and documentation
- Leading on ethical decisions in conjunction with multi-disciplinary team taking into consideration the family/carer views when appropriate.
- Monitoring of biochemical and other laboratory parameters, e.g. urea and electrolytes
- Monitoring for medicine interactions/adverse reactions and whether the therapy is achieving the desired therapeutic effect.

Unit Manager

The unit manager and their nominated deputies are responsible for ensuring that all hospital staff comply in full with this guideline and that staff are competent in the practice and have attended appropriate training.

Certain professional groups and have specific responsibilities.

Dietitian

The dietitian is responsible for:

- The assessment and monitoring of patient's nutritional status.
- Advising on the appropriateness for enteral feeding.
- Advising 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.

Pharmacist

The pharmacist is responsible for:

- Advising on and monitoring the safe, effective, and economic use of medicines.
- Monitoring for medicine interactions/adverse reactions and whether the therapy is achieving the desired therapeutic effect.

Unit Staff

Unit staff are responsible for:

- The ordering and maintaining of stock levels of standard enteral feeding equipment, specifically:
 - Fine bore nasogastric tubes (the tubes must be fully radio-opaque with markings to enable accurate measurement, identification, and documentation of their position)
 - 60ml enteral feeding syringes. These should meet the requirements of NPSA guidelines no 19 (2007)
 - CE accredited pH strips with a range of 0-6 in 0.5 graduations
 - Appropriate feed as recommended by the dietetic department
- The completion of physical observations in accordance with NEWS2 both during and following the use of an NG tube as a minimum. When restraint has been required the observations required as a minimum as highlighted within the Trust Physical Restraint Policy.

5. INDICATIONS FOR NASO GASTRIC FEEDING

Whenever possible oral food intake is always preferred and the use of a nasogastric tube should only be considered when there is a serious threat to the young person's physical health, i.e., individuals who have been diagnosed with an eating disorder and have a body mass index low enough to be of serious risk. Examples of instances where the insertion of a tube may be considered for insertion include:

- Support in psychiatric diseases such as anorexia nervosa where the young person is unable, due to their eating disorder, to fulfil their nutritional requirements with normal/modified diet and/or nutritional supplements.
- There is the potential for NG feeding to be used to support young people with psychiatric diagnoses such as obsessive-compulsive disorder, psychosis and severe depression when all other means of encouraging oral intake have failed and the young person's physical health is compromised due to ongoing food restriction/ refusal.
- Prolonged food or fluid refusal or hunger strike
- Urgent medication or hydration requirements.

5.1. Risk Assessment

The decision to NG feed a patient is a medical decision and must be made on an individual basis and as part of a multidisciplinary assessment of the person's needs in consultation with the patient, their family where appropriate and members of the wider multi-disciplinary team including therapists and dietitians.

A full risk assessment must be undertaken by two competent health care professionals including the senior doctor responsible for the patient's care/ the dietitian/ the junior medic. The assessment must include an assessment and consideration of the risks and benefits of staying at the Inspire Inpatient Unit over transfer to the general hospital.

The indication and rationale for complete or partial enteral feeding will be clearly written in the patient's clinical 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 nasogastric tube for the purpose of feeding.

Drugs/fluids can also be administered via this NG tube if needed as part of the patient's individual treatment plan.

A regular review of the continued requirement to NG tube feed any individual must be held by a member of the medical team in consultation with the MDT. Independent Advocacy should be involved in all reviews whereby a patient lacks capacity. A summary of the review of the NG tube feeding and any decisions made must be documented in the patient's clinical notes. This should include a list of people participating in the review.

5.2. Consent and capacity

If the child/young person has capacity, their wishes should be considered as clinically assisted nutrition is considered a medical treatment as opposed to basic care (food and drink).

Prior to insertion of an NG tube, the procedure and any risks should be explained to the **child/young** person so that informed consent, written/verbal/signage, can be obtained, written information regarding the procedure will be given to the patient.

5.2.1 Young people 16 and 17 years of age

Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there is significant evidence to suggest otherwise.

There may be circumstances when the young person lacks the capacity to make a decision about this specific element of their care. If, following a mental capacity assessment, the young person is deemed to not have capacity with regards to nasogastric feeding then the decision needs to be made in accordance with the [Mental Capacity Act and Best Interest Decision Making Policy](#).

The support of an appropriate advocate such as the Independent Mental Capacity Advocate (if 16 years or over) should be considered.

5.2.2 Children under 16

For "Children under the age of 16 year the MCA does not apply. Instead, a child needs to be assessed whether they have enough understanding to make up their own mind about the benefits and risks of treatment – this is termed Gillick competence" (CQC, 2020). It is good practice to provide parents with information and this should be documented in the clinical record.

Children under 16 who are not Gillick competent cannot either give or withhold consent to treatment. People with parental responsibility need to make the decision on their behalf (Brief guide BG004 Dec 2017). For further details see [Mental Capacity Act and Best Interest Decision Making Policy](#) and [Consent Policy N-052.pdf \(humber.nhs.uk\)](#)

If a child under the age of 16 or a person with parental responsibility is unable to give informed consent, then treatment should be considered in the context of the Children Act 1989 or the Mental Health Act 1983.

All assessments regarding Gillick competence should be undertaken before treatment commences and stored in patient records.

5.2.3 Compulsory treatment

Feeding against the will of the patient should be an intervention of last resort in the care and management of those with severe eating disorders or other mental illness.

There should be evidence in the records that risks have been considered and explored. This includes whether refusal may result in significant harm to the child and that safeguarding concerns have been considered.

If a child or young person lacks capacity, their physical health is at serious risk and they do not consent to treatment, ask their parents or carers to consent on their behalf and if necessary, use an appropriate legal framework for compulsory treatment (NICE, NG69, 2017)

Treatment should be considered in the context of the Mental Health Act 1983, the Mental Capacity Act 2005 or the Children Act 1989 (and their respective Codes of Practice) depending on the age of the patient and their MHA status.

A multidisciplinary approach should be taken when deciding on the appropriateness of enteral feeding for a patient. The individuals consent or clear reasons for consent not being obtained must be recorded in the patient's clinical notes, in compliance with statutory requirements.

The goals and rationale of the treatment should be clearly identified in the patient's clinical notes.

Evidence of a discussion with family members, where appropriate, is required. This should be documented in the patient's clinical notes. There may be occasions where the young person does not consent to their treatment by NG feeding with capacity but the responsible adult with parental responsibility does consent for the NG feeding to take place. Parents cannot override a competent child's refusal to accept treatment. Where a competent child under 16 refuses a specific treatment which is in their best interests, but the parents support the recommendation for treatment, there should be evidence of that providers have attempted to understand both the child's and parents' position. There should also be evidence that alternative treatments have been considered or a compromise is not possible. However, ultimately the decision rests with the competent child or the Court of Protection.

In these difficult circumstances the Inspire team can contact the Mental Health Legislation Team or the Humber Safeguarding Team for advice.

Further guidance for staff on information giving and informed consent are available within the Trust Consent policy.

5.3. The Use of Restrictive Practices

Training provision should take into account the difference between restraint and holding still for clinical procedures and be targeted at relevant groups of health care professionals. Health care professionals working with children, young people, learning disability and vulnerable adults should receive training relevant to their clinical area this is an integral part of the DMI Model adopted by the Trust. Due to the safety pods being used in restraints for NG feeding purposes staff must have relevant DMI training regarding utilising the safety pods, under no circumstances should staff who

have not been trained in these techniques be involved in restraints of this nature. The use of safety pods must adhere to the CAMHS Safety Pod Standard Operating Procedure.

Health care professionals working with children and young people and vulnerable adults in all areas should receive training in holding still for clinical procedures and de-escalation techniques. This training must be based on a person-centred approach and take into account the 'Best Interests' of the person.

Any training in physical interventions/clinical holding must comply with the Trust's [Physical Restraint Policy](#). Training must be provided by a qualified physical intervention instructor. The care plan should clearly specify that any training provided is to be used solely for the specified treatment in the care plan.

Physical restraint must be used with great caution in children and young people due to the increased risk of injury associated with immature musculoskeletal systems. Restraint has been identified as harmful to children and young people. Please see section 5.6 of the Trust [Physical Restraint Policy](#).

6. PROCEDURE

Nasogastric tube placement should be carried out during the day to ensure sufficient experienced support is available to accurately confirm nasogastric tube placement.

If following the insertion of an NG tube and/or subsequent enteral feeding a patient experiences any of the following the ward or on-call doctor will be contacted and asked to review the patient urgently:

- prolonged vomiting
- persistent diarrhoea
- repeatedly not being able to obtain an aspirate
- abnormal abdominal distention
- abdominal pain

Following review by the ward or on-call medic, liaison with the paediatric ward at HRI may be necessary in order to gain specialist advice and potential admission to the acute services.

In acute or emergency situations patients should be transferred immediately to the acute for assessment. See [Deteriorating Patient Policy](#) and [Deteriorating Patient Protocol](#)

PH indicator strips must be CE marked and intended by the manufacturer to test human gastric aspirate.

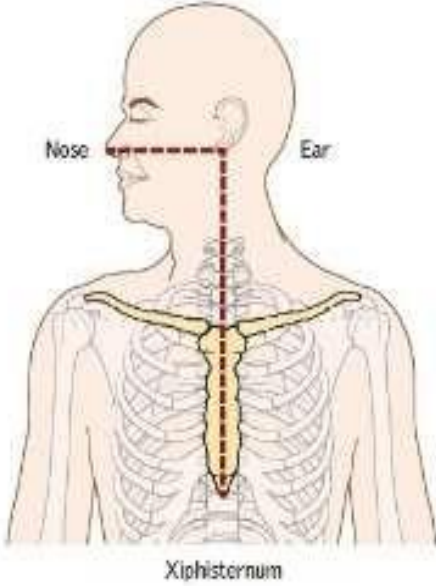
It is essential that the young person and family when appropriate should have had psychological preparation to reduce the distress caused by the procedure.

A minimum of two people are needed when passing a NG tube on a consenting young person. This is to ensure that there is one staff member to comfort and provide support.

6.1. Procedure

Procedure	Rationale	Reference
Action 1. Gather all necessary equipment		
<ul style="list-style-type: none"> • Non-sterile gloves and disposable apron • 1 sterile gallipot. • CE marked pH paper that is capable of indicating an acid range of pH 0-6. • 1x20ml and 1x50 ml syringe (or manufacturer's recommendations). • Radio-opaque NPSA compliant feeding tube appropriate for intended use. Nasogastric tubes used for the purpose of feeding must be radio-opaque throughout their length and have externally visible length markings • A glass of drinking water or squash. • Water for flushing the tube (in accordance with local policy). 	To ensure no interruptions to the procedure all equipment should be gathered prior to approaching the young person.	Patient Safety Alert (NHS/PSA/RE/2016/006) Nasogastric tube misplacement: continuing risk of death and severe harm. London. NPSA 2011
Action 2. Patient preparation		
<ul style="list-style-type: none"> • Agree a signal with the young person in order that they can indicate a problem or their wish to pause the procedure, e.g., raising a hand. • Advise them of the need to perform a swallow as they feel the tube passing through the pharynx (if able to do so). 	To facilitate a smooth passage of the tube and provide reassurance to the patient.	British Association of Parenteral and Enteral Nutrition (2012)
Action 3. Apply infection control principles		
<ul style="list-style-type: none"> • Wash hands before putting on gloves and apron – follow the five moments for hand hygiene. • Ensure universal precautions are used • Put on the necessary personal protective equipment, i.e., gloves, apron. • Utilise an aseptic non-touch technique. • Prepare equipment on a clean surface area. 	Reducing the risk of contamination	Trust Hand Hygiene Policy ANTT Policy Standard Precautions Policy
Action 4. Position the patient		
Ensure the patient is in a position that is safe for the Insertion of the tube. Ideally upright	To increase patient comfort and avoid inadvertent tracheal intubation	Dougherty, Lister, West-Oram (2015)

Action 5. Measure the length of the nasogastric tube

<p>The approximate length of the tube is ascertained by measuring the tip of the tube from the nose to ear lobe, then to the stomach aiming for the space in the middle below the ribs (xiphoid process) note marking on the tube (see diagram below).</p> <p>Note the predetermined mark. This may be completed by marking the tube with a pen.</p> <p>Ensure the end cap is left open, to ensure accurate placement in the stomach.</p> <p>The NEX measurement is:</p> <ul style="list-style-type: none"> • The measurement taken to identify the length of NG feeding tube to be inserted. • The measurement is taken from the bridge of the patient’s nose to the earlobe and then to the tip of the xiphisternum. 	<p>To ascertain an approximate measurement to ensure the tip of the nasogastric tube reaches the stomach</p>	<p>Stroud et al (2003) NPSA (2011)</p>
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Action 6. Inspect and examine the nose

<ul style="list-style-type: none"> • Select a nostril that is clear and free from any debris. • If replacing a tube however it is preferable to use the alternative nostril from which the tube was originally placed if appropriate, to prevent long term irritation and skin damage. 	<p>To ensure nasal passage is clear and smooth for insertion of the tube</p>	<p>Eccles 2000 Dougherty, Lister, West-Oram,2015</p>
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Action 7. Preparation of equipment		
<ul style="list-style-type: none"> Remove the nasogastric tube from its package. Gently manipulate the guidewire to ensure it moves freely within the tube. Lubricate the outside of the tube with water or water based lubricant 	<p>To allow easier removal of the guidewire following tube insertion</p> <p>To facilitate the smooth passage of the tube and increase comfort</p>	NPSA 2012

Action 8. Procedure for the insertion of the tube		
<ul style="list-style-type: none"> Gently insert the rounded end of the tube into the agreed nostril aiming towards the back of the nose and along the floor of the nose towards the nasopharynx ensuring the head is not hyperextended. If any obstruction is felt try again at a slightly different angle or by using the alternative nostril. Where a patient is safe to swallow fluid and has capacity, offer a glass of water/squash with a straw and ask the young person to swallow some water. 	To reduce the risk of tracheal intubation	Stroud et al 2003 BAPEN/NNNG 2012

Action 9. Advancing the nasogastric tube		
<ul style="list-style-type: none"> Advance the tube to the predetermined NEX measurement. If any significant resistance is felt during insertion halt the procedure and pull the tube back but do not remove it completely. If at any time the young person becomes unduly distressed or a change in their colour, stop the procedure and remove the nasogastric tube immediately as this may indicate the passage of the tube into the trachea. Try again once the patient has settled. If the patient starts to cough during the procedure, stop, pull the tube back slightly and wait for coughing to settle. Before continuing, ask the patient to open their mouth to check the nasogastric tube has not coiled up at the back of the oral cavity. If the patient becomes distressed it is advisable to stop and seek senior specialist advice. A maximum of two attempts in one feeding period should be made at any one time. Following procedure is unsuccessful after two stop and seek senior advice. 	<p>To achieve gastric positioning of the tube</p> <p>To avoid the need to replace in to the nasal passage</p> <p>To avoid causing harm</p>	BAPEN/NNNG 2015

Action 10. Confirm the correct position of the tube		
<p>Once the nasogastric tube has been inserted to, or slightly beyond, the predetermined NEX mark:</p> <ul style="list-style-type: none"> • Leave the guidewire in position (if there is a guidewire). • Connect a 60ml enteral syringe onto the end of the nasogastric tube. • Exert gentle pressure to withdraw aspirate along the length of the nasogastric tube into the syringe. You only need a small amount of aspirate to test. • Test the aspirate obtained, with pH indicator paper/strips that are CE marked for human gastric aspirate. • The pH reading must be 5.5 or below before feed, fluid or medication can be administered via the nasogastric tube. The aspirate reading must be checked by 2 staff members (1 staff member undertaking this task must be qualified and completed NG training and competencies) and both to initial on the documentation that they have checked the reading. 	<p>To allow for the tube to be repositioned if necessary</p> <p>To confirm correct gastric position and that it is safe to feed</p> <p>To reduce displacement of the tube. Securing the nasogastric tube to the cheek rather than the nose reduces the risk of nasal erosion.</p>	<p>NPSA 2007 NPSA 2011</p>

<ul style="list-style-type: none"> • If the pH reading is above 5.5 or unable to obtain aspirate, no feeding to commence and actions must be taken in accordance with the NPSA decision tree below (Appendix 1). • If aspirate can't be obtained ask the patient to lie on their left side and try to obtain aspirate again. If aspirate still cannot be obtained remove the tube and repass a new tube and repeat. If aspirate still cannot be obtained the 2nd time then the patient will need to go to acute hospital for an x-ray to check the placement of the tube. • A small amount of lemon juice can be used to check if the tube is placed correctly when the PH is above 5.5, if the patient is willing to drink this orally, once they have drank this wait 10- 20 minutes and then retest the aspirate to see if the PH has gone down if so the tube is in the stomach. The lemon juice should not be put down the NG tube in any circumstances. • If the PH satisfactory, secure the nasogastric tube at the nose or cheek once gastric position is confirmed. • Remove the guidewire. Note that if a guidewire is removed and the nasogastric tube requires repositioning, under no circumstances should the guidewire be reinserted into the tube in situ. • Flush the tube with water as per patient's individualised meal plan. 		<p>Boeykens et al 2014 Gilbertson et al 2011 NPSA 2005 Jones et al 2015</p> <p>NPSA 2011</p>
<ul style="list-style-type: none"> • Make the young person comfortable. Ensure they are in a position that is safe prior to administering a feed or fluids. <p>If patient is being restrained including management of the head for the feed, they must be on the safety pod at a 45 degree angle to ensure safety during feeding. They should not be laid flat due to risk of aspiration.</p>	To maintain patient comfort and safety	DH 2013
Action 11. Administration of Feed		
<ul style="list-style-type: none"> • Prepare the patient's feed as per their meal plan and water down the feed with sterile water as indicated in the patient's individualised meal plan, this makes the feed easier to pass and supports hydration for patient's who are not taking adequate fluids. • Feed should be administered using the syringe bolus method this is where the feed is administered using a 60 ml syringe using a stop start motion and delivering approximately 1 syringe per minute initially 		<p>Trust Waste Policy</p> <p>Standard Precautions Policy</p> <p>Hand Hygiene Policy</p> <p>British Dietetics Association, mental health specialist group.</p>

<p>and increasing to 2 syringes per minute as tolerated as per BDA guidance.</p> <ul style="list-style-type: none"> • Once all the feed has been administered flush the tube with water as per meal plan. • If administering medications via the NG tube flush the tube with 10mls of water pre and post and in between each new medication. Each medication should be administered separately and should never be added to the feed. • Once all feed and medication if required has been administered gently remove tape and fully remove the tube. Dispose of this in the clinical waste bin. • Offer the patient a tissue or sips of water. • Dispose of equipment and PPE in accordance with the Trust Waste Policy • Decontaminate hands 		
<p>Action 12. Documentation requirements</p>		
<ul style="list-style-type: none"> • Fully document procedure in the patient records both on paper chart in the clinical room and on Lorenzo. It should include as a minimum: • The date and time tube inserted. • The size and type of nasogastric tube used. • NEX cm measurement. To be checked and documented each feed. • In which nostril the tube is situated. • The method used to confirm gastric positioning of the tube. Document PH reading and which 2 staff members confirmed this. • Details of healthcare professional who inserted the tube including name and designation. • Any problems experienced during the procedure. • Amount of feed and fluid given via NG tube to cross reference the meal plan. • Appropriate patient notes or bedside charts (as per local guidance) • Also consider documenting on Lorenzo: • Patient tolerability of the procedure. • The number of attempts undertaken to insert the nasogastric tube. • A fluid balance and nutrition chart must be maintained on Lorenzo. 		

6.2. Flushing of the Enteral Feeding Tube

Flushing is the single most effective action that prolongs the life of nasogastric tubes. It is recommended that flushing occurs:

- Following initial insertion.

If NGT is left in situ:

- At least once daily when being used.
- Before the administration of each bolus of feed or fluid.
- Before medication, if feed not in progress.
- Before commencing a new cycle of feed or fluid.

It is important however that position of the nasogastric tube is always confirmed/rechecked prior to flushing or administration of any feed/medications, and in particular following any episodes of vomiting, retching or coughing spasms or when there is a suggestion of tube displacement. Please note that NGTs will not be routinely left in situ and the decision will be undertaken through MDT discussion and a detailed risk assessment.

DO NOT FLUSH THE FEEDING TUBE IN THE FOLLOWING SITUATIONS:

- When there is suspicion or evidence of tube displacement e.g. length of tube at nostril is less than previously documented or securement device has loosened.
- If there are any new or unexplained respiratory symptoms or reduction in oxygen saturation.

A 60ml enteral syringe should be used for flushing the tube. It is important to always use the largest size of enteral syringe. This is because the larger the syringe, the less pressure is placed upon the enteral device avoiding potential damage.

A pulsatile flushing action (push/pause technique) should be practiced when flushing to promote a turbulence effect within the tube. This ensures the adequate flushing of the device and will help to prevent any blockage. The volume of the flush administered must be in line with their current meal plan and recorded in the young person's record.

6.3. Troubleshooting

PROBLEM	ACTION	PREVENTION
Blocked tube	<ul style="list-style-type: none"> • Try flushing tube with warm water (Dandelees, Lodolce 2011) • Roll the tube between your fingers • Use a gently plunging action to withdraw and insert tube contents • NB the above actions may take up to 30 minutes • Do not use cola, pineapple juice etc. as this may damage the tube. 	<p>To avoid blocking the tube flush the tube thoroughly before and after each feed/medication</p> <ul style="list-style-type: none"> • Ensure medications are flushed down the tube in their appropriate form

Persistent diarrhoea (>24hours)	<ul style="list-style-type: none"> • Contact dietitian • Stool sample to be obtained for culture and sensitivity • Medication to be reviewed • Consider anti-diarrhoeal if infective cause ruled out • Review osmolarity and fibre content of feed 	<ul style="list-style-type: none"> • Observe good hygiene practices when administering the feed • Once opened do not use any feed after 24 hours. • Single items/single patient use items only to be used
Nausea/Vomiting/Abdominal Distension	<ul style="list-style-type: none"> • Review medication • Rule out constipation • Consider prokinetics 	<ul style="list-style-type: none"> • Start slowly and gradually build up to prescribed volume
Constipation	<ul style="list-style-type: none"> • Review laxative medications • Review fluid provision • Review fibre content of feeding regime 	<ul style="list-style-type: none"> • Maintain Bristol stool chart

6.4. Incident Reporting

Any Incident of misplaced NG Feeding tubes being undetected and being used for feeding must be reported to the National Reporting and Learning System. This is one of the incidents referred to as a “Never Event”.

An incident report must be completed, using the hospital electronic incident reporting system DATIX, where an incident relating to the misplacement or mismanagement of an NG tube occurs.

An incident report (DATIX) must be completed for each NG feeding episode where restraint is utilised.

7. STAFF TRAINING AND COMPETENCE

Training Requirements

The clinical lead is accountable for ensuring that staff are aware of this guideline and associated training requirements.

An NG tube must only be inserted by a member of staff of Humber Teaching NHS Foundation Trust who has undergone appropriate training and is deemed competent, or by a member of staff who is in training and is under the supervision of a competent health professional.

Staff involved in inserting and feeding via NG tubes are responsible for actively participating in the training including refresher training sessions and ensuring they are familiar with this guideline and the guidelines for use. See Appendix 3.

The Unit Manager and Clinical Lead for Eating Disorders at Inspire are responsible for ensuring all staff involved in the insertion and feeding via NG tubes have successfully completed the competencies and have documentation in their file and on ESR to confirm this. The competency framework to be utilised for the insertion of NG tubes is the Nasogastric Tube Feeding Training and Competency Framework- Inspire Inpatient Unit.

All staff who are involved in the insertion and position checks of NG tubes and the delivery of feeds should ensure that they are assessed as competent through theoretical and practical training. This will involve the staff member undertaking face to face training and subsequently demonstrating competent practice on a minimum of two occasions. The staff member can be signed off by a registered professional who can demonstrate their own competencies and have documentation to support this.

The skills and competencies of staff in the insertion and management of tubes/tube feeding will be reviewed on a 3 monthly basis for those who have not passed an NG tube for 3 months they will be expected to demonstrate their competencies on the mannequin at Inspire and recomplete the self-assessment competency framework. For those staff who have not passed an NG tube on a patient for a year they will have to complete the full training again and this will include updated information to reflect any new practice in the management of NG tubes. In the clinic room on Inspire there will be a folder with a paper copy documenting every NG feed done at Inspire and who administered this as well as paperwork on Lorenzo to reflect this which will be audited fortnightly to establish who is administering the feeds and ensure that it is noted when a staff member has not completed an NG feed for 3 months. Once it has been recognised that a staff member needs to review their competencies a meeting will be arranged to address this as soon as possible. The outcome of this review will be documented in the staff personnel file and within the central training records and it is again up to the Clinical Lead for Eating Disorders and the Ward Manager to ensure the training is completed, up to date and the records are accurate on ESR.

Where physical restraint by staff may be required in order to facilitate a feed via NG tube a registered nurse who is trained in DMI must be present and will be responsible for directing and subsequently documenting and reporting of the restraint. A minimum of 3 staff performing the restraint with an additional staff member responsible for overseeing the feed is required. All restraints for NG feeding should be in line with the DMI training specific to this intervention and the use of safety pods, anyone who has not had this specific training should not be involved in the restraints during NG feeding.

8. EQUALITY IMPACT ASSESSMENT

This policy has been assessed using the Equality Impact Assessment Screening Tool. The assessment concluded that the policy would have no adverse impact on any of the diverse groups detailed. These include the strands of disability, ethnicity, gender, gender identity, age, sexual orientation, religion/belief, social inclusion and community cohesion.

9. REVIEW DATE

This guideline and procedure will be reviewed in one year from its initial approval and then 3 years thereafter, or in light of relevant legislative or organisational changes.

10. ACKNOWLEDGEMENT

Special thanks are given to Riverdale Specialist Eating Disorders Policy for allowing us to share their Enteral Feeding for Adolescents using a fine bore nasogastric tube (published February 2019).

11. RELEVANT TRUST POLICIES/PROCEDURES/GUIDELINES

- [CAMHS Inpatient Service Eating Disorders SOP](#)
- [Nutrition Guideline for the CAMHS inpatient](#)
- [CAMHS Safety Pod SOP](#)
- [Hand Hygiene Policy](#)
- [Standard Precautions Policy](#)
- [Consent to Treatment under the MHA SOP](#)
- [Consent Policy N-052](#)
- [Mental Health Act Legislation Policy](#)
- [Physical Restraint Policy](#)
- [Deteriorating Patient Policy](#)
- [Deteriorating Patient Protocol](#)

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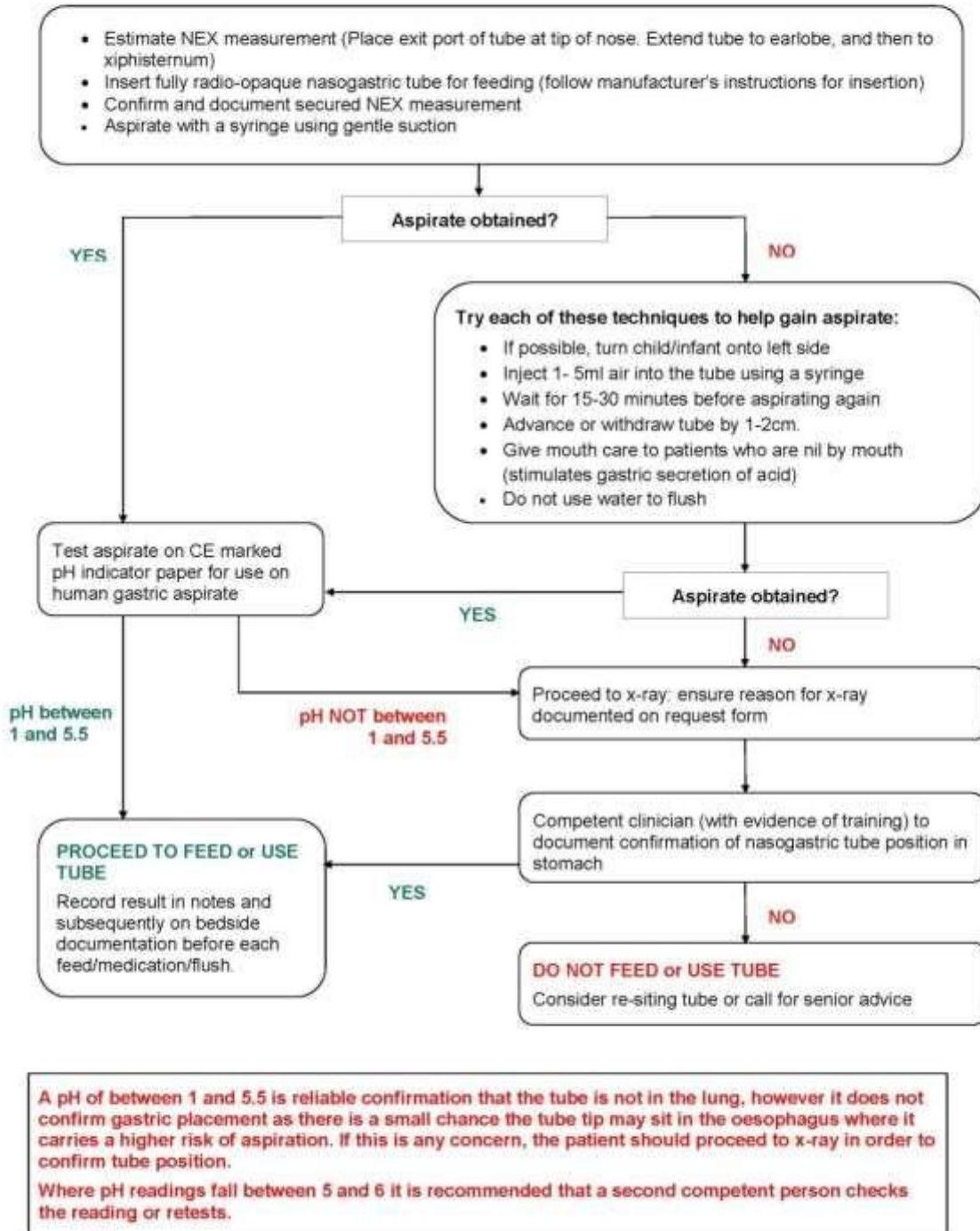
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Southern Health NHS Foundation Trust Nasogastric Tube Insertion and Maintenance Policy

Version 2 2015 <http://www.southernhealth.nhs.uk/EasysiteWeb/getresource.axd?AssetID=42323>

Appendix 1: Decision Tree for Nasogastric Tube Placement Checks

Decision tree for nasogastric tube placement checks in **CHILDREN** and **INFANTS** (NOT NEONATES)



www.npsa.nhs.uk/alerts

Appendix 2: RECORD OF NASOGASTRIC INSERTION AND ONGOING CHECKS

Nasogastric tube placement checklist

This should be completed for all patients requiring nasogastric tube placement, on all insertions, before administration of nutrition via the nasogastric tube.

Patient Name:

NHS Number/Hospital Number:

DOB:

Ward:

Nasogastric tube insertion

<u>Date</u>									
<u>Time</u>									
<u>NEX measurement</u>									
<u>Nostril used</u>									
<u>Aspirate obtained</u> <u>Y/N</u>									
<u>pH of Aspirate</u>									
<u>X-ray required Y/N</u>									
<u>Inserted by:</u>									
<u>pH Checked by:</u>									
<u>Tube removed Y/N</u>									
<u>Feed and Fluids given:</u> (Use prescription for guidance)									

Appendix 3: Nasogastric Tube Educational Pathway for Practitioners

Element	Method/frequency
Proven successful completion of the approved Nasogastric Training	Face to face training facilitated by approved training provider
Practical assessments with mentor and competency sign off	Live supervision with mentor and completion of competencies on a minimum of 2 occasions
Immediate life support and anaphylaxis training	Annually
Infection control training and hand hygiene	As per local policy and statutory/mandatory training requirements
Proven competence with the Trust's core clinical competencies	As per role requirement 3 yearly Core Clinical Competencies (humber.nhs.uk)
Re-assessment if the practitioner has not had any practical experience in 3 months	Complete Trust's NG competencies with practical demonstration on the mannequin Role Specific Clinical Competencies (humber.nhs.uk)
Re-assessment if the practitioner has not had any practical experience in 1 year	Complete full training

Appendix 4: Equality Impact Assessment (EIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. **Document or Process or Service Name:** Guideline for the Safe Insertion of Fine Bore Nasogastric Feeding Tubes for Young People Requiring Enteral Feeding as Part of the Eating Disorder Pathway (CAMHS Inpatient Unit)
2. **EIA Reviewer (name, job title, base and contact details):** Rachel Douglas Clinical Lead for Eating Disorders at Inspire (RMN)
3. **Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other?** Guideline

Main Aims of the Document, Process or Service		
Nasogastric tube feeding is a necessity for a minority of young people with Eating Disorders, however the number of nasogastric tubes being used in CAMHS inpatient units has been growing over a number of years and it is imperative that there are clear guidelines for not only when we should use nasogastric tube feeding but also how we should use these, with a recognition in the guidelines of the risks associated with nasogastric tube feeding and how we can limit the risk of harm to the young people. Nasogastric tube feeding should be considered a life saving treatment and be used as such with persistent food refusal especially when young people are at low weight to the point where it is impacting on their physical health. It is important that the CAMHS Inpatient unit within Humber NHS Foundation Trust has the correct training and guidelines in place to offer this intervention safely for those young people at risk of significant deterioration due to their Eating Difficulties/ Disorders.		
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma		
Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
Age	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern (Amber) High = significant evidence or concern (Red)	1. who have you consulted with 2. what have they said 3. what information or data have you used 4. where are the gaps in your analysis 5. how will your document/process or
Disability		
Sex		
Marriage/Civil Partnership		
Pregnancy/Maternity		
Race		
Religion/Belief		
Sexual Orientation		
Gender re-assignment		

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people, Young people, Children, Early years	Medium	This guideline is currently only for use in the CAMHS inpatient unit whose service runs for those between 13 and 18 years old
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory, Physical, Learning, Mental Health (and including cancer, HIV, multiple sclerosis)	Medium	Should there be any young people with disabilities which effect areas of the body such as soft palate, esophagus, skull, stomach/ digestive system liaison with acute trust HUTH would be indicated for potential reasonable adjustments to be made/ alternative treatment
Sex	Men/Male, Women/Female	Low	This guideline is not influenced by gender
Married/Civil Partnership		Low	This guideline is applicable to all regardless of marital status
Pregnancy/ Maternity		Low	
Race	Colour, Nationality, Ethnic/national origins	Low	This guideline is not influenced by race or ethnicity

Religion or Belief	All Religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	This guideline applies equally to all regardless of religion or belief
Sexual Orientation	Lesbian, Gay Men, Bisexual	Low	This guideline equally applies to all regardless of sexual orientation
Gender re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	This guideline equally applies to all regardless of gender reassignment

Summary

<i>Please describe the main points/actions arising from your assessment that supports your decision above</i>			
Due to this guideline being written for a specific service (CAMHS inpatient unit) it will undoubtedly impact on age as it is not applicable to any other area in the Trust. Disability must be taken into account with the risks associated with passing tubes when there is certain damage or abnormalities to particular parts of the body which the tube would pass through. The CAMHS inpatient service is not equipped to offer treatment in these instances therefore more specialised treatment in the acute trust would be necessary.			
EIA Reviewer	Rachel Douglas (RMN)- Clinical Lead for Eating Disorders at Inspire		
Date completed	January 2023	Signature	R. Douglas