NASOGASTRIC TUBE MANAGEMENT

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**Clinical Guideline Statement**

**Aim:** This learning package has been developed to assist nurses/midwives in achieving confidence and to ensure contemporary practice in the care and management of the following patients:

- Patient requiring insertion of a nasogastric tube
- Patient requiring enteral feeding via a nasogastric tube

**Objectives:** Upon successfully completing this learning package, self-assessment tool and skill demonstration assessment the Registered Nurse (RN) / Enrolled Nurse (EN) / Registered Midwife (RM) will be able to;

- Describe what a nasogastric tube is and the common uses for it.
- Identify the different types of nasogastric tubes and when to use each one.
- Accurately measure a patient for a nasogastric tube.
- Describe the process of nasogastric insertion.
- Ensure correct placement of a nasogastric tube.
- Discuss how to insert both a fine bore feeding tube and a wide bore nasogastric tube.
- Administer medications via a nasogastric tube.
- Describe how to problem solve a blocked nasogastric tube.
- Identify potential complications of nasogastric tube insertion.
- Describe the process of removal of a nasogastric tube.
- Identify nursing management of the patient requiring enteral feeding.
- Identify the differences in nasogastric tube management for paediatric patients.

**Scope of practice & clinical protocols** – it is your responsibility to ensure that you are familiar with the following Epworth HealthCare Protocols

- Insertion and removal of NG tube
- Enteral Feeding (Adult) Protocol
- Indwelling nasogastric tube feeding of neonates protocol
Nasogastric Tubes

Definition

A nasogastric tube (NGT) is any tube placed via the nose and passed down the oesophagus with the tip ending in the stomach.

Indications for Use

Nasogastric tubes can be inserted to relieve gastric distension by removing gas, gastric secretions, or food; to instil medication, food or fluids or to obtain a specimen for laboratory analysis. After surgery and in any condition in which the person is able to digest food but not eat it, the tube may be introduced and left in place for tube feeding until the ability to eat normally is restored (Anderson, 1998).

When used for gastric drainage, the tubes are usually larger to allow for aspiration and emptying of thick gastric fluid, though when used for feeding or instilling medication, the lumen of the tube is much smaller to prevent pharyngeal and nasal irritation.

Nasogastric feeding is usually considered as a first line in artificial nutritional support and therefore should be considered as a short term method of feeding, normally no more than six weeks. If a patient requires long term tube feeding due to dysphagia, a gastrostomy or jejunostomy tube may be considered which is surgically inserted.

Contraindications for nasogastric tubes include:

- maxillofacial or basal skull fractures,
- recent gastric, oesophageal or maxillofacial surgery
- maxillofacial disorders or trauma
- laryngectomy
- unstable cervical spinal injuries
- oesophageal or oropharyngeal tumours or surgery, oesophageal varices
- complete intestinal obstruction (Shlamovitz & Shah, 2008)
- severe gastroesophageal reflux disease (GORD)
- established clotting disorders/problems
- mucositis
Different Types of Nasogastric Tubes

The size of the NGT is very much dependent on the intended use of the tube and how long the tube will be in situ.

Nasogastric tubes can be used for decompression of the gastrointestinal tract, diagnosis and assessment, nutritional support, fluid rehydration and medication administration.

Tubes are measured in Fr meaning French, which measures the gauge or diameter of the lumen. The larger the number, the larger the diameter of the tube; i.e. a 12Fr is larger than an 8Fr.

The most common nasogastric tube is the double –lumen gastric, Salem sump tube made of clear plastic. It is useful for irrigating the stomach but is most often used for aspirating fluid and gas from the stomach. It is the preferred tube for gastric decompression.

The single-lumen Levin tube is made of plastic or rubber with several drainage holes near the gastric end of the tube. This type of tube is useful for decompressing the stomach, withdrawing specimens for pathology, flushing the stomach free of toxic substances, and irrigating the stomach to diagnose and treat upper gastrointestinal bleeding. It can also be used to administer feeds and/or medications.

Soft, flexible, small diameter 8 Fr to 12 Fr tubes are frequently used for patients who require enteral feeding for less than 6 weeks. However, firmer, less flexible, larger diameter tubes, 14Fr or larger are used to administer medications, gastric decompression, or for short term feeding (usually less than 1 week) (Griffiths, Thompson, Chau, & Fernandez, 2006).
The fine bore nasogastric tube is a single lumen polyurethane tube. It has a radio-opaque guide wire to stiffen for insertion and a radio-opaque marker on the tip. The fine bore tubes are of small diameter and made of soft material and more comfortable for the patient. However, these attributes can also result in:

- Increased risk of tube blockage
- Rupture or kinking of the tube
- Increased likelihood that misplacement will not be detected

Fine bore feeding tubes can be used to aspirate, however using gentle suction via syringe is required to prevent damage to the tube.

**Selection of naso-gastric tubes for paediatric patients**

- Select appropriate size NGT for infant/child according to age and clinical indication.
- Factors to consider when selecting appropriate size NGT include:
  - Anticipated duration of feeding/treatment (Short term NGT – PVC are routinely to be used and may be required to be changed weekly. Refer to manufacturer’s product instructions. If long term use is required, then polyurethane NGT is to be used, which generally requires to be replaced every 4 weeks. Refer to manufacturer’s product information.
  - Comfort for child: ability to breathe around NGT
  - Type, thickness and mode of fluid administration (gravity or via enteral feeding pump)
  - NGT inserted for drainage or decompression of the stomach
- Generally for infants/small children a size 8 FG is used (6 FG for small infants) and larger size 10 FG for children > 12 years.

Note: long term NGT e.g. polyurethane tubes may include a stylet, which is removed after NGT inserted. Refer to manufacturer’s product instructions. If stylet is not used consider placing NGT in freezer prior to insertion to reduce the pliability of NGT and thus assist with insertion.
Insertion of Nasogastric Tubes

**Before Insertion**

The procedure should be discussed with the patient so that they are aware of the rationale for insertion of a nasogastric tube. Verbal consent must be obtained from the patient/parent and documented in progress notes.

The order should be verified, including the type and size of the nasogastric tube and/or what it will be used for and whether or not it will be attached to suction.

The patient’s history should be reviewed for nasal surgery or presence of a deviated septum. The patient’s level of consciousness and ability to cooperate are assessed. A baseline abdominal assessment is undertaken, including whether their abdomen is soft or firm, distended or flat, whether there are any bowel sounds and if the patient is nauseated.

The length of the tube to be inserted is estimated to ensure its location in the mid to distal stomach. Measure the distance of the tube from the patient’s earlobe to the bridge of the nose plus the distance from the earlobe to the bottom of the xiphisternum (NEX measurement).

If the patient has had a CVA, check that they have been reviewed by speech pathology, and assess for the presence of a gag reflex. If a patient does not have a gag reflex, you cannot ask them to sip water whilst inserting the nasogastric tube.

**Preparation of an infant/child for naso-gastric insertion**

**Communication, Comfort Measures & Distraction Therapies**

- Explain procedure to child and parents, ensure age appropriate language/explanation is used
- Source items e.g. toys to distract child during NGT insertion when age appropriate.
- Consider use of sucrose for infants less than 18 months for comfort during NGT insertion.
- Consult with treating doctor for the distressed child if procedural sedation needs to be considered e.g. intranasal medication.
- Ensure as much as possible all equipment is prepared prior to child being present.

**Procedural Positioning**

- **Child/Infant**: Use age appropriate procedural positioning e.g. infant lying flat, child sitting up when possible and in close proximity to parent. Refer to Appendix for Comfort Kids – Positioning infant/child fact sheets. Two nursing/midwifery staff may be required to perform/assist with NGT insertion.

Child/infant needs to be positioned-supported in a manner that prevents hyperextension of the neck. Maintaining the child/infant’s head tilted slightly forward will assist in closing the epiglottis and open the oesophagus. Consequently, when infant/small child lying down for the procedure it may be necessary for the nurse assisting with the procedure to place a hand underneath their head to prevent them from throwing their head back, particularly since a distressed child/infant will arch their back, resulting in throwing their head back.

**Insertion**: refer to Insertion and Removal of nasogastric tubes protocol.
Checking Correct Placement of a Nasogastric Tube

The position of the NGT is confirmed via testing of stomach contents with pH indicator strips. A pH level of 0.0-5.5 is indicative of accurate placement. A pH 6.0 and above indicates an increased risk of incorrect placement. If a pH of >6 occurs the NGT should not be used and confirmation of placement should be obtained via x-ray.

Xray can be used to confirm position of a nasogastric tube however it must be remembered the position can change after xray and pH aspiration will still be required. For all patients (adults and paediatrics) xray confirmation is a last resort, troubleshooting methods should be exhausted. Xray will only be requested after discussion with the treating Doctor and their order to proceed. Feeding via the tube must not commence until the correct position of the tube has been confirmed, note ongoing aspirate checks will still be required after xray confirmation.

Visual assessment of the colour of the aspirate may help identify tube placement during insertion. However colour of aspirate must not be used to confirm placement. Gastric aspirate is most frequently cloudy and green, tan or off-white, or bloody and brown, it may also contain milk/formula or food particles. Intestinal fluid is usually yellow or bile stained. Pleural fluid is usually pale yellow, clear and serous (Ackley, Ladwig, Swan & Tucker, 2008).

Techniques to obtain aspirate:

- Turn patient on left side
- Inject air into NGT (Adults 10-20mls via 50ml syringe, Paediatrics 1-5mls via 10ml syringe)
- Wait 15-30 minutes and attempt to aspirate again
- Advance or withdraw NGT and attempt to reaspirate (adults 10-20cm, paediatrics 1-2cm)
- Give mouth care to patients who are NBM (can stimulate gastric secretions)
- **DO NOT** flush with water as water in the tube could lead to false pH values being obtained

Often aspirate can be obtained by waiting and returning to attempt aspiration after turning patient and injecting air. Refer to Nasogastric Tube Placement Check flow chart.
Nasogastric Tube Placement Check

Estimate NEX measurement
Fully insert NGT (as per manufacturer instructions) to NEX point
Aspirate NGT Adults: 20ml syringe and gentle suction Pediatrics: 10-20ml syringe and gentle suction

Aspirate obtained?

YES

Test aspirate using pH indicator paper

pH 0.5-5.5

Commence feeding
Document pH in progress notes MR12
Continue to check pH as indicated: before medication/feed commenced, once every 8 hours, or if concerned tube may have moved

pH 5-6

Second person checks pH of aspirate
Recheck aspirate after 30-60 mins
Discuss with nurse in charge/doctor: resite OR x-ray?

pH 5.5 - 6 *

NO

Techniques to obtain aspirate:
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✓ Inject air into NGT (Adults 10-20mls via 50ml syringe, Pediatrics 1.5mls via 10-20ml syringe)
✓ Wait 15-30 minutes and attempt to aspirate again
✓ Advance or withdraw NGT and attempt to reaspirate (Adults 10-20cm, Pediatrics 1-2cm)
✓ Give mouth care to patients who are NBM (can stimulate gastric secretions)
✓ DO NOT flush with water as water in the tube could lead to false pH values being obtained

Aspirate obtained?

Discuss with treating doctor
Remove and resite OR x-ray?
If x-ray ensure reason for request is noted, so radiographer ensures NGT tip is visible

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Limitations of pH testing include:

- pH of stomach can be affected by medication, e.g. antacids, H2 antagonists and PPI’s have a high pH
- pH of stomach can be affected by enteral feeds feeding formulas for paediatric patients (Most formulas have pH between 5 – 7.5, expressed breast milk is 7.2). If readings out of required range 0 – 5.5, leave for up to one hour before re-attempting aspiration

Limitations of radiography:

- increased number of x-rays increases the exposure to radiation and impacts on the patients feeding regimes
- access to radiology outside of hospital may be difficult
- x-rays can be misinterpreted by medical staff that are not trained in radiology
- The x-ray confirms the position of the NGT at the time of the x-ray only. Further checks to confirm position will be required e.g. prior to feed/medication.

Do NOT use the following to check NGT placement:

- whoosh test (auscultation of air through the feeding tube)
- testing acidity/alkalinity of aspirate using blue litmus paper
- monitoring bubbling at the end of the tube
- observing the appearance of feeding tube aspirate
- interpreting the absence of respiratory distress as an indicator of correct positioning

When to check the position of the nasogastric tube

- following insertion of the tube
- before administering each feed/water flush
- before administering medication
- following episodes of vomiting or excessive coughing
- following evidence of tube dislodgement
- if there are any concerns that the end of the tube is not in the stomach
- if the patient suddenly shows signs of respiratory difficulty

If you are in doubt of nasogastric tube placement, discuss with nurse in charge and doctor it may be preferable to remove and reinsert the tube, rather than xray (particularly for paediatric patients).

Actions to be taken if difficulty obtaining aspirate

There are a number of reasons why aspirate may not be immediately obtainable after the nasogastric tube is inserted;

- Air in syringe but no aspirate – the tube may not have reached the level of gastric secretions. Slowly advance the tube a maximum of 10cm and repeat the aspiration.
- No air or aspirate obtained – the tube may be occluded by being placed up against gastric mucosa. Gently withdraw the tube a small amount and attempt aspiration.
- No air or aspirate obtained – the tube may have been advanced too far and into the duodenum. Very slowly pull back on the tube and attempt to aspirate.
- Aspirate amount is less than 0.5ml. This may be due to low levels of gastric secretions. Position the patient onto the left lateral side and if possible at 30 degrees and attempt to aspirate again.
The position of the tube must be checked as failure to confirm can lead to the administration of fluid, medication or feed directly into the lungs resulting in aspiration pneumonia.

The position of the tube must be checked with pH testing and recorded on a chart at the patient’s bedside and/or via x-ray.

Refer to Nasogastric Tube Placement flow chart for actions if difficulty aspirating. If after attempting all of the above trouble shooting methods, you are still unable to obtain aspirate, discuss with treating physician.

**Securing a Nasogastric Tube**

Once tube placement is confirmed, the NGT is secured so that it does not fall out or become easily dislodged. An adhesive nasogastric stabilisation/securing device is applied, as shown below.

![Securing the nasogastric tube](image)

The securing of a nasogastric tube in a paediatric patient is different to that of an adult. For paediatric patients a hydrocolloid is applied to the child’s cheek from as close to the nares as possible, then secure the nasogastric tube using an adhesive dressing over the hydrocolloid.

![Paediatric securement](image)

**Nasal Bridles:**

Nasal bridles may be used to reduce the risk of a patient removing the NG tube. The patient is deterred from removing the tube due to pain caused by pulling on the tube. Currently these are not inserted at Epworth HealthCare, but may be present on transfer to Epworth hospitals. More information can be obtained from the AMT Bridle website.
Caring for the patient with a nasogastric tube

Every 8 hours the nurse needs to perform the following checks of the nasogastric tube;:

- The visible length of the tube from the tip of the nose should be measured to ensure that it has not migrated, and documented.
- The oropharynx needs to be inspected for coiling.
- The nares should be inspected for formation of pressure injuries.
- Maintain oral hygiene frequently. Encourage mouth rinses and lubricate lips.
- Ensure the nares are kept clean, especially around the tube where secretions accumulate.
- Ensure the tube is taped securely to the nose (or the cheek in a child) to prevent trauma to the nares and change as needed. Check for signs of pressure during routine care. If used: ensure nasal bridle clip is not resting on nares.
- Ensure bridle clip and tapes are secure, but not too tight, observe for signs of swelling or discolouration.
- pH checks as indicated below.

Dislodgement of Nasogastric Tubes

Nasogastric tube position should be checked at least once every 8 hours if having continuous feeds, before commencing a feed, before administering medications or more frequent if clinically indicated. It is also important to be aware that the tube can become dislodged after vomiting and/or coughing, and its position should therefore be re-checked following any episodes of coughing, vomiting or retching.

To check position:

1. Ensure cm marking on tube aligns with initial insertion length recorded
2. Check pH of aspirate using pH indicator paper NG

Patients who are confused or small children/babies will often pull on their tubes, so be sure that it is well secured. If a nasogastric tube has become dislodged, inform the consultant and assess whether it needs to be reinserted (Cannaby, Evans, & Freeman, 2002).

Flushing Nasogastric Tubes

All NGT and enteral feeding tubes require regular flushing to prevent blockage (for care of tubes other than NG tube refer to appendices of Enteral Feeding protocol), The tube should be flushed with warm or tepid tap water that is safe for drinking before and after each feed and pre and post medication administration. The dietitian will supply instructions regarding the amount to be administered. Flushing of minimum 30mLs must be done before and after each medication is administered into the tube. In addition to this, regular water flushes every 4-6 hours must also be done for hydration if a person is nil orally as directed by the Dietitian. In paediatric patients nasogastric tubes may be flushed with 5-20mLs of water. Sterile water should be used in children under 12 months. Refer to enteral feeding protocol.
Potential Complications of the Nasogastric Tube Insertion Procedure

There are several potential complications of nasogastric tube insertion, including; bronchial placement, intracranial insertion, nasal trauma, pharyngeal or oesophageal pouch perforation or precipitation of variceal bleeding. See the table below for signs, symptoms and management of these complications (Best, 2007).

<table>
<thead>
<tr>
<th>COMPLICATION</th>
<th>SIGNS AND SYMPTOMS</th>
<th>MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronchial Placement</td>
<td>Respiratory Distress</td>
<td>Remove tube immediately Check O2 saturations Attempt to re-insert tube once pt breathing has settled</td>
</tr>
<tr>
<td>Intracranial Insertion</td>
<td>Change in level of consciousness</td>
<td>Remove NGT immediately Perform neurological observations Inform treating doctor <strong>immediately</strong> Escalate and follow emergency protocols</td>
</tr>
<tr>
<td>(Only occurs in pts with skull malformations, skull/facial fractures or trauma)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal Trauma</td>
<td>Bleeding from nares</td>
<td>Remove NGT Apply pressure at bridge of nose Hold gauze at the end of the nose Cold packs on the back of their neck Observations Inform treating doctor</td>
</tr>
<tr>
<td>Pharyngeal or Oesophageal Pouch Perforation</td>
<td>Bleeding from mouth and/or nose, haematemesis, haemoptysis, pain</td>
<td>Remove NGT Suction PRN Observations Keep pt NBM Inform treating doctor <strong>Escalate and follow emergency protocols</strong></td>
</tr>
<tr>
<td>Precipitation of Variceal Bleeding</td>
<td>Haematemesis, haemoptysis, pain</td>
<td>Remove NGT Suction PRN Inform treating doctor <strong>Escalate and follow emergency protocols</strong></td>
</tr>
</tbody>
</table>
Medication Administration via a Nasogastric Tube

Before any medication is given into an enteral feeding tube, the placement of the tube must be checked and the tube must be flushed with water to ensure patency. Flushing of the tube must be done before and after each medication. When flushing an enteral feeding tube, you may use tap water that is safe to drink, in children under 12 months sterile water is to be used, ensuring that it is room temperature or tepid, to prevent muscle spasms or discomfort to the patient.

Medications should be obtained in liquid or soluble tablet form if possible to ensure patency of the tube. However, some medications can be crushed and then diluted in water before flushed into the NGT. If unsure if a medication can be crushed, consult the pharmacist. Each medication should be administered separately and a flush given in between. If all medications are administered together and the tube becomes blocked it is not possible to determine what drugs were administered and the correct dosage. Medications should not be administered while a feed is running. The feed should be stopped and flushed with a minimum of 30mLs of water prior to administration. In paediatric patients the tube should be flushed with 5-20mLs of water.

Following administration of all required medications, the volumes administered should be documented on the fluid balance chart.

Sustained release and enteric coated tablets and granules should not be crushed. Check with the pharmacist to see if there are any other ways to give the medication.

Refer to Epworth protocols regarding enteral feeding and medication administration.

Removal of a Nasogastric Tube

If a patient no longer requires their NGT (either because they no longer need enteral feeding via this method, or they have tolerated clamping of the NGT for 24 hrs or more) and an order has been obtained from the doctor to discontinue the NGT, then it may be removed.

To remove an NGT, the tube is flushed with a small amount (i.e. 10mLs) of warm tap water to rid the tube of any debris and to ensure that it is not stuck to the gastric lining. Then remove the securing device (scissors are required to cut bridle is in situ). Ask the patient to take a deep breath and then slowly pull out the tube in one continuous motion. (Note – a bowl nearby may be appropriate and a towel placed under the patients chin, as they may feel the need to vomit after the tube is pulled past the soft palate in the back of the throat). Refer to refer to Insertion and Removal of nasogastric tubes protocol.

After removal of the NGT, document the procedure in the patient progress notes.

An example of what you might write in the progress notes after removal is:

“14Fr salem sump NGT flushed with 10 mLs of water. NGT easily removed. Pt tolerated procedure well. Abdominal assessment completed five minutes after removal to find, pt’s abdomen flat and soft, bowel sounds in all four quadrants and pt denying nausea. Pt allowed to start on sips of water according to Dr.Smith. Jug of water given to pt, and pt instructed to only take sips, and to do so as he tolerates”.
Enteral Feeding

Enteral feeding is considered when an individual is not safe for oral intake, unable to eat or when oral intake is inadequate to meet nutritional requirements. Enteral Feeding involves the administration of a pre-made formula containing the required nutrients. This feeding method may deliver total or supplemental nutrition.

Nasogastric tube feeding may be used as a short term method of tube feeding for people who are malnourished (recent significant weight loss, anorexia, food aversion), have suffered an acute event which they are expected to recover from (surgery, mild stroke causing temporary dysphagia) require a trial of tube feeding or require tube feeding but are awaiting a permanent surgically implanted feeding tube (i.e. gastrostomy or jejunostomy) (Barrett, 2004).

Children may require enteral feeds for a number of reasons including, the inability to consume adequate nutrients or increased nutritional requirements, an impaired swallow/suck, anorexia, eating disorders, structural abnormalities of the face or oesophagus.

Enteral feedings maintain the structural and functional integrity of the GI tract by preventing atrophic changes. In addition, they prevent cholecystasis by stimulating bile flow. Compared with parenteral feeding, enteral nutrition improves systemic immunity and lowers infection risk (Abrogast, 2002).

Contraindications for enteral feeding are; complete intestinal obstruction, severe oesophageal reflux, oesophageal fistula and gastric fistula (Barrett, 2004).

Longer term nasogastric feeding is less common than short term feeding; however, it can be useful for people who are unable to have an anaesthetic or people who have limited abdominal access for a surgically implanted tube (Barrett, 2004).

Tube feeding is performed either by bolus, intermittent or continuous feeding methods. The mode of administration is determined by the dietitian. Once the dietitian has made their recommendation, it must
be ordered by the consultant before you start the feeding regime. In paediatric patients the method of feeding may be determined by the treating paediatrician.

Intermittent and continuous feeding methods are delivered by a feeding pump and infusion tubing. Bolus feedings are delivered by syringe or by feeding pump and infusion tubing. Enteral feeding pumps are available on most wards.

The dietitian determines the appropriate feeding regime following a nutritional assessment.

- Refer to Epworth Healthcare Clinical Procedure Guidelines – Enteral Feeding (Adults) Protocol

Caring for the patient requiring enteral feeding

- Ensure the correct positioning of the tube
- Administer the correct formula as instructed on the Enteral Nutrition Plan (MR46Z).
- Record on fluid balance chart including flushes
- Change feeding sets every 24 hours.
- Regular abdominal assessments should be performed each shift. Bowel sounds need to be assessed to ensure the presence of peristalsis and a functional intestinal tract. Distension of the abdomen, nausea and vomiting should be noted.
- Documentation of bowel movements. If the patient has diarrhoea, do not cease the feeding. Report to the dietitian to determine if a change of feed or a reduction in the rate of administration is required. In most cases, tube feedings do not cause diarrhoea. Assess and address possible other causes of diarrhoea, such as medications. Frequent offenders include magnesium-containing antacids, sorbitol dissolving drugs and antibiotics (Arbogast, 2004).
- Monitor patient for gastric distension or pain
- Maintain oral hygiene frequently. Encourage mouth rinses and lubricate lips.
- Ensure the nares are kept clean, especially around the tube where secretions accumulate
- Ensure the tube is taped securely to the nose (cheek in paediatric patients) to prevent trauma to the nares
- Monitor vital signs – especially tachycardia or sudden increase in blood pressure
- Monitor body weight – weekly or as ordered
- Monitor blood tests – electrolytes and serum phosphate

Aspirates for volumes are only undertaken it requested by the doctor or dietitian.

When a patient is having nasogastric tube feeds, the head of the bed SHOULD ALWAYS be at a minimum of 30 degrees. If you have to lay a patient flat, i.e. to change their position, you must turn off the nasogastric feeds. This helps minimize the risk of aspiration. If a patient’s head of the bed cannot be raised for clinical reasons, i.e. chronic subdural hematomas, or recent back surgery or trauma, you may be able to tilt the entire bed to reduce the risk of aspiration.
References


Royal Childrens Hospital, 2015. Enteral feeding and medication administration. Clinical Practice Guideline (Nursing)


