Nasogastric Feeding Tube Discharge - Risk Assessment - Full Clinical Guideline

Reference No: CG-T/2023/171

1. Aim and Purpose

This clinical guideline applies to all adult patients discharged with a nasogastric (NG) feeding tube. A risk assessment must be completed for all of these patients.

Managing a nasogastric tube feeding in the community is usually the responsibility of the patient or their family members, it is therefore vital that all aspects of the care required, and the potential risks involved are carefully considered prior to the decision being made to discharge a patient with a nasogastric feeding tube. The risk assessment is designed to identify and reduce any risk associated with NG feeding at home and to ensure that appropriate support is available following discharge.
The discharging consultant remains responsible for arranging insertion of replacement tubes.

The risk assessment must be completed to fulfil NPSA (NPSA/2011/PSA002) recommendations which state.
"A full multidisciplinary supported risk assessment is made and documented before a patient with a nasogastric tube is discharged from acute care to the community".

2. Keywords

- Nutrition
- Enteral Feeding
- NG Tube
- Nasogastric Tube
- Discharge
- Risk assessment

3. Risk Assessment

Process:

- MDT discussion/meeting with completion of capacity assessment/ best interest decision if necessary.
- The risk assessment to be completed by the consultant responsible for the patient. (**All** sections must be completed)
- Refer to the nutrition nurses and dietitians for training and supply of necessary equipment (a minimum of 48 hours notice is required)
- Training will be provided for patient/relative responsible for managing nasogastric feeding.
- Patient /relative will practise and become competent in the skills required before being discharged.

Sections for completion:

1. Consultant responsible for completion of the risk assessment
2. Patient details
3. Medical history, indication and goals.
4. Capacity to consent
5. Responsibility for care of tube and administration of feed
6. NG tube and insertion procedure details
7. Arrangements for planned and unplanned replacement of NG tube
8. pH testing history
9. Arrangements for review of indications and goals
10. Training record

4. Appendices

Appendix 1. Decision tree for nasogastric tube placement checks in ADULTS

1. Consultant responsible for completion of the risk assessment.

An MDT meeting/discussion must be undertaken to facilitate this process and include everyone involved in care delivery, (Example: The person being discharged, next of kin, Doctor, Home Enteral Feeding dietitian, ward dietitian, nutrition nurse, social worker, speech and language therapist) details of the MDT meeting/discussion must be documented in medical notes. Best interest decision should be made at this time if appropriate.

Consultants name	
Telephone number	

Date of MDT meeting	
Expected date of discharge	

2. Patient details

Name			
D.O.B.		Hospital number	
NHS number			
Discharge address			
Telephone number		Mobile number	

3. Medical history, indication and goals

Diagnosis	
Relevant PMH	
Indication for nasogastric feeding	
Goals for NG feeding	
Anticipated length of time NG feed will be required	

4. Capacity to consent (tick as appropriate)

Does the patient have capacity to provide consent for necessary interventions?	YES		NO	
If no, date capacity assessment completed				
Date best interest decision and paperwork completed (if patient does not have capacity)				

5. Responsibility for care of tube and administration of feed (tick as appropriate)

Who will take responsibility for overall care? (must be a relative if patient does not have capacity/ability)	Patient		Relative	
Who will deliver necessary care? (must be a relative if patient does not have capacity/ability)	Patient		Relative	

6. NG tube and insertion procedure details

NG tube details	Make		Size	fr	cm
Date inserted		Tube length at the nose		cm	
Method of insertion	Bedside		Radiological		

The discharging consultant remains responsible for arranging insertion of replacement tubes, planned or unplanned.

a. Procedure for routine planned tube change.

Date of first planned change (if tube due to be changed within the next 7days, please change prior to discharge)	
Name of department/ person who will change the NG tube. (every 90 days)	
Telephone number	

b. Procedure for urgent / unplanned re-insertions

Out of hours, patients with a blocked or displaced tube who are entirely dependent on the NG tube for feed, fluids, or medication, should contact 111 or out of hours GP to arrange admission or attend ED. If they are able to wait until the next working day - they should contact the team responsible for insertion of the tube.

Name of department/person to contact	
Telephone number	

c. Tube insertion

If tube insertions are difficult, please state how this is managed?

7. pH testing history

Last 7 days pH readings (to be taken from pH testing form)

Date	pH reading	Was x-ray needed?

If pH consistently more than 5.5; how will this be managed in the community?

8. Arrangements for review of indications and goals

Name of person who will review the ongoing need for NG feeding	
Telephone number	
Planned date/timescale of review	

9. Training record

Training will only take place once the risk assessment has been completed.

Aspect of care	**Name of person/s trained**	**Name and designation of trainer**	**Signature of trainer**	**Date training completed**
Management of NG tube				
Management of pump				
Other (state)				

To be completed by the named Consultant from the discharging hospital:

Following an MDT meeting, it has been agreed that this patient can be safely discharged with an NG tube as described in this document.

Consultant signature	
Print name	
Date	

This assessment confirms the clinical situation at the time of discharge. It is anticipated that changes over time may make these care arrangements impractical or inappropriate. An assessment can be requested by the patient and any person involved in the care. Please contact the person who has taken responsibility for reviewing this care.

This form to be filed in patient's medical notes and copy to every person involved in the discharge.

Documentation controls

Development of Guideline:	Lead Nutrition Nurse
Consultation with:	Nutrition Consultants
Approved By:	Nutrition and Hydration Steering Group Nutrition team July 2023 Gastro-subdirectorate 27/9/23 Medicine Division Nov 2026
Review Date:	November 2026
Key Contact:	Lead Nutrition Nurse

Appendix 1

Decision tree for nasogastric tube placement checks in ADULTS

Any Community Setting

NG tube insitu.
Use a 60ml syringe to obtain gastric aspirate before each use.

Test aspirate on pH strips
(Must be CE marked)

Aspirate obtained?

Yes

No

Try each of these techniques in turn to help get an aspirate:

1. Look at external tube length and compare to initial measurement (recorded on risk assessment tool)
2. If possible, turn patient onto left side
3. Inject 10-20ml air into the tube to move debris/mucosa from the tube tip
4. Wait 15-30 min before aspirating again
5. Give mouth care to patients who are nil by mouth to stimulate gastric secretions
6. If patient can drink, ask them to drink a coloured and easily identified drink

Do not flush the tube with any liquids until pH is determined

Aspirate obtained?

Yes

No

pH 5.5 or below

pH above 5.5

No

Proceed to feed or use tube.
Record results.

Option 1 – repeat attempts to aspirate and return to top of decision tree. The algorithm will inform how long you persevere with this option.
OR
Option 2 – discuss with Nutrition nurse, decision about the need and most appropriate timing for x-ray.

DO NOT FEED OR USE TUBE

PPI or H2 antagonist use can cause the pH of gastric fluid to be raised. When these drugs are being used (and NG tube position has been confirmed on insertion by x-ray), the NG tube may continue to be used even if subsequent pH readings continue to fall between 5 – 6, as long as feed is tolerated and the external position of the tube has not changed. However a second competent person must check the reading or retest the pH prior to use.

A pH of 5.5 or less is reliable confirmation that the tube is not in the lung, however it does not absolutely 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 aspiration or feed regurgitation occurs proceed to x-ray in order to confirm tube position.