PATHWAY/OPERATIONAL GUIDELINES FOR PATIENTS (ADULT ONLY) WITH A NASOGASTRIC TUBE (NG) WITHIN A HOME ENVIRONMENT OR COMMUNITY HOSPITAL

These guidelines and pathway reflect the recommendations from the National Patient Safety agency (NPSA) and are to be used in conjunction with the:

- North Cumbria University Hospital Nasogastric Policy Ref :CG11
- North Cumbria University Hospital Local Safety Standards for invasive procedures (Loc SIPP) Insertion of Nasogastric tubes.

These guidelines and pathway are to be implemented within the community hospital and community nursing teams.

PRIOR TO DISCHARGE - *Prior to accepting a referral form the discharging hospital, please ensure the following information is in place.*

Roles and Responsibilities – Secondary care

A full multidisciplinary discussion and supported risk assessment should be made and documented, before a patient with a nasogastric tube is identified for discharge from acute care to the community. Guidance on ongoing confirmation of nasogastric tube placement by community staff should be provided and communicated with this risk assessment.

The risk assessment to be agreed by the consultant in secondary care and the community nursing team who will be caring for the patient at home or in a community hospital inpatient unit.

Establish which consultant will have the responsibility of the ongoing care management monitoring and review of the patient whilst in the community setting.

Written robust patient care planning by the referrer which should include the following information:

- Reason for insertion of NG tube
- What are the ongoing care needs of the patient on discharge from secondary care.
- End date or planned review date if end date is unknown.
- Details of the medication/feeding regime
- Ensure 7 days supply of equipment, medication and nutritional feed and details of ongoing supplies
- Identified Consultant who has the ongoing care management of the patient whilst in the community
- Details of others involved in the patients care i.e. dietician/SALT/OT

Roles and Responsibilities - CPFT Community Nursing team and community hospitals

A patient specific risk assessment *must* be completed for each individual patient. CPFT nursing teams *must* consider the following factors prior to accepting a referral from secondary care. Care needs of the patient need to be balanced against the risk in providing care in a community setting.

The community nursing service or community hospital inpatient unit must establish if they have the staffing capacity/resource to provide care for the patient whilst an NG tube insitu

The NPSA recommend **two registered nurses** to undertake repeat confirmation of NG tube positioning prior to the following:

- Before administering a bolus feed
- Before giving medication
- Before administering feed/water following a rest period
- If the patient has been observed vomiting, retching or coughing
- If the patient becomes acutely distressed, breathless or has difficulty breathing.

Non Compliance- Consideration must be given to patients who are none compliant to treatment/care due to confusion, mental capacity, acute mental illness or behavioural difficulties. This does not exclude these patients however risk needs to be balanced against need.

Environmental factors such as location of patient's home, telephone contact to summon help, suitability of home in which to provide care.

Physical factors- if the patient is experiencing nausea and vomiting or where there is a high risk of displacement.

Training and competency- All practitioners who are involved in the ongoing care management of patients with an NG tube must:

- Accept accountability and responsibility for their practice
- Adhere to the policies details above.
- Must be registered with the Nursing and Midwifery Council (NMC)
- Attend face to face training and gain competency in the management of NGT. A minimum of 5 competencies to be gained – 2 simulated and 3 real time/live competencies.

Operational Training plan:

- NCUHT Ward /service lead identifies potential discharge of patient with NGT to clinical educators from NCUHT – Sheena Bleasdale and CPFT Sue Harper and to CPFT ward/service lead.
- Sue Harper/Sheena Bleasdale contact CPFT Lead to establish a training plan to support discharge plan.
- Training will be conducted on site to Community/Ward Team by Sue & Sheena
- Acute Hospital Ward/Sheena will facilitate access to patient to complete On-going Care competency profile for CPFT staff.

Community NG Tube pathway and checks

PRIOR TO DISCHARGE

Assessment to be completed and agreed by the consultant in secondary care and community team who would will be caring for the patient
(Refer to National Patient Safety Alerts and NCUHT NG policy section 5.9 Competency and 5.13 Transfer of care and that the following is in place)

1. **MDT**
2. **Individualised Risk assessment carried out and agreed**
3. **Written robust patient care planning by the referrer with an end date or planned review date if end date is unknown.**

NO

NOT IN PLACE
The NCUHT team to consider other relevant options to an NG tube

YES

ONGOING CARE AFTER DISCHARGE

Checks to be carried out by CPFT registered nurses as per pathway before every administration via NGT.
ASSESS the tube position (LocSIPP Appendix 3)

- The initial placement has been properly documented on the NG insertion chart.
- The measurement of the external mark at the nose must be equal to or beyond the original NEX measurement (i.e. the tube has moved further into the stomach/gut). If measurement of the external mark at the nose is less than the original NEX measurement (i.e. indicating the tube has moved upwards and out of the stomach/gut) do not use the tube.
- No visual sign of a coiled tube in oral cavity

IF NOT CONFIRMED

DO NOT INSERT ANY FEED /LIQUID as per NG policy
Contact secondary care referring consultant to consider if NG is still required or not

If YES: refer back to Secondary care for check / re insertion of NG

If NO: what is the hydration/nutrition plan?

YES CONFIRM
Aspirate the NG tube using a **NEW** 50ml enteral syringe applying gentle suction

NO ASPIRATE OBTAINED
Referring to LocSIPP section 3.1.2 attempt the following :

- Turn patient on their left side and whilst in this position, undertake mouth care to stimulate gastric secretion and retry aspiration after 15 - 30 minutes
- Insert 10-20mls of air into the tube (to move the tube in the stomach). DO NOT carry out auscultation of air to test tube position (Whoosh test).
- Using a 20ml enteral syringe attempt to aspirate 0.5 to 1.0ml of stomach contents
- If the patient is able to swallow, and they are not nil by mouth, ask them to drink a small amount of liquid

YES ASPIRATE OBTAINED- Procedure as per LocSIPP 3.1

Indicator strip: CE mark/IN date/for Human Aspirate

Confirm aspirate is within safe range of pH 1- 4

Proceed to use the NG tube and document findings and checks as per NCUHT bedside chart (Appendix 2 LocSIPP)

If PH unclear or above 4 refer to secondary care

NO ASPIRATE OBTAINED

CPFT Nurses to leave the patient for 1-2 hours

Repeat NG Pathway once more only.

Failed checks and NO Aspirate
DO NOT INTRODUCE ANY LIQUID OR FEED INTO THE TUBE
Contact and arrange immediate referral to secondary care referrer as per discharge plan for second line testing or reinsertion as required.