Keele University Teaching Trust
NHS
North Staffordshire Combined Healthcare NHS Trust

Our Ref: NG/RM/25416
Date: 19th December 2025

Nicola Griffiths
Deputy Director of Governance
North Staffordshire Combined Healthcare NHS Trust
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ST4 8HH

Reception: 0300 123 1535

Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 28th November 2025**.** Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:

I would be grateful if you could provide copies of any internal guidelines, protocols, policies or standard operating procedures that relate specifically to mealtime/ dining room support in the treatment of eating disorders within your services. This includes, but is not limited to, documents that cover:

- Expectations and roles of staff during mealtimes.
- Levels of supervision and support before, during and after meals or snacks.
- Management of meal related distress, behaviours or incidents.
- Use of any structured mealtime programmes or approaches.
- Nasogastric feeding or the use of oral nutrition supplements.

If different guidelines are used in different settings, please provide all relevant documents. For example, where your organisation has a separate or adapted guidance for:

- Inpatient wards.
- Day hospital or day programme services.
- Intensive outpatient / intensive community treatment.
- Outpatient or community services.

Similarly, I would also be grateful if you could provide all protocol versions, if different protocols apply to different age groups, including:

- Adult eating disorder services.
- CAMHS / children and young people's eating disorder services.
- All age or transition services, if applicable.

The Trust community teams offer meal support on an individual basis- Please see Appendices 1 and 2 attached.

Local processes for the Darwin Centre:

- **Expectations and roles of staff during mealtimes**
  Clear expectations are in place for staff roles during mealtimes, with defined responsibilities to support patients appropriately while maintaining boundaries and consistency.

- **Levels of supervision and support before, during and after meals or snacks**
  Levels of supervision and support are individualised, based on clinical need/ diagnosis, and provided before, during and after meals and snacks to ensure physical safety, emotional support and adherence to care plans.

- **Management of meal related distress, behaviours or incidents**
  Meal-related distress, behaviours or incidents are managed calmly and therapeutically, using de-escalation strategies and agreed behavioural plans. Staff aim to reduce anxiety while maintaining clear expectations and responding promptly to risk.

- **Use of any structured mealtime programmes or approaches**
  Structured mealtime programmes and evidence-based approaches are used where appropriate, aligned with individual care plans and multidisciplinary guidance.

- **Nasogastric feeding or the use of oral nutrition supplements**
  please see Appendix 3 attached- Nasogastric feeding and the use of oral nutritional supplements are implemented when clinically indicated, following established protocols and with ongoing monitoring and support.

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

Nicola Griffiths
Deputy Director of Governance

Meal Support-Protocol

-Meal support need identified and agreed in team meeting. Review progress every 4 weeks and plan accordingly. To check minutes/handover for any changes to plan from MDT if not in attendance.

HCSW to place names on calendar and decide timings if more than one meal support that day.

-Advise parents/education/ relatives where appropriate of when they will be attending each week.

- regular weekly meal support meeting held to identify new cases requiring meal support.

- Regular supervision in place for HCSW

- Feedback to care co with any concerns

Meal Support

The young people in our care all have eating difficulties. They often struggle to eat certain foods and can avoid meals or foods they consider dangerous. The body must be re-nourished for the body and mind to recover. Young people need support to develop new eating habits that reduce effects of malnourishment and consume a broader range of foods. Young people must make these changes despite persistent eating disorder thoughts and intense anxiety.

Meal support is an extremely important tool to help patients transition back to healthy eating habits. All patients who are hospitalised receive complete meal support. During meal support we aim to expose patients to fear foods and unlearn conditioned eating disorder behaviours such as restriction, slow eating, deconstructing food, cutting food into tiny pieces, taking tiny bites, etc.). During meals, irrational thoughts about food can also be discussed and challenged.

A vital part of meal support is helping parents to learn to stay calm in the face of their child's anxiety attacks and angry outbursts, supporting them through completing their meals including foods they fear. Our Meal Support Team are experienced specialist practitioners who will support carers to: remain calm, be confident, be consistent and be compassionate.

Young people may be supported by one of our Healthcare Support Workers who can offer meal support (at home or in school during meal times). Our Healthcare Support Workers are able to provide extensive support around portion guidance and approaches during mealtimes. Here are some things to expect from meal support.
Our team member - usually a Support Worker - will need access to your home at meal times and we require that a pre-agreed parent/guardian is present at all times

- The team member may be male or female. We have 3 Support Workers currently who work within the team
- The team member will be firm and boundaried during mealtime to support the young person to challenge any thoughts that they are struggling with. It is important that meal support boundaries and the expectations of everyone are clear before eating begins. Examples of boundaries include: The young person has 30 minutes to eat the meal, the person must take bigger bites, and meals must contain a balance of carbohydrate, protein, vegetables, and a fat source. Reminders of agreements and boundaries can be helpful to get through a meal. For example we might say: "We

agreed that we don't change plans and goals during a meal. Let's stick to the plan and talk about it later".

- The team member will be modelling behaviours and strategies parents/ guardians will need to use. The team member may need to sit immediately adjacent to the young person or in their proximity
- The team member may hold or offer the young person the food that they are expected to eat during the meal time. This will have been prepared by parents/guardians.
- The team member will aim to support the young person and the parent/guardian for however long it takes for the meal to be finished. We will work towards this being 30 minutes for meal times but the team member may also offer pre or post meal support.
- Meal support can be intense, emotional and upsetting at times as we understand meal times can be difficult and anxiety-provoking to start with. Our Support Workers are there to support you through this
- Our Support Workers may be accompanied by students at times – we will always ask you first
- We understand it can feel unusual to have a Support Worker in your home at meal times so
- we will be considerate of this
- We will confirm times and which Support Worker is attending prior to the meal support but request your understanding if there are unexpected delays beyond our control.
- We try to be flexible and fit around your family meal times but we may not always be able to accommodate them.
- If the young person is being seen in school, the Care Co-ordinator will speak to school to arrange this and let school know to expect a Support Worker to attend at mealtimes

Standing Operating Procedure for the safe Insertion of Nasogastric Tube (NGT) for Children and Adults

Standard Operating Procedure(SOP) Details

SOP Reference Number	**1.62c**
SOP Lead/Author (Name and Job Title)	Head of Nursing and Professional Practice Ward Manager Service Manager QILN/Matron Lead Dietitian Deputy Ward Manager
Responsible Department	Nursing & Quality Directorate
Executive Director whose portfolio this SOP comes under	Kenny Laing
Committee/Group Responsible for Approval of this SOP	Clinical Excellence Group / Physical Health Group
Date of Approval	29th October 2025
Date of Review	31st October 2028
State if SOP is **New** or **Revised**	New
Disclosure Status on Internet Yes/No	

Review and Amendment History

Version	Date	Description of Change
V1.0		New Standard Operating Procedure

Contents

Why do we have a procedure?

Nasogastric feeding has been a common practice within healthcare in all service user groups. Thousands of nasogastric feeding tubes are inserted daily, however there is a small risk that the nasogastric feeding tube can be misplaced in the lungs during insertion or can migrate out of the stomach at a later stage.

This procedure has been developed to support clinical staff in the correct insertion of nasogastric (NG) feeding tubes and in the confirmation of tube placement to reduce risk to service users in line with current evidence-based practice.

This procedure is critical to the delivery of personalised care that improves the lives of people who access our services.

Service users in inservice user settings may require Naso-Gastric (NG) tubes for nutrition, fluid and/ or medication, as recommended in NICE guidance for a short term usage. This Standard Operating Procedure (SOP) ensures that all North Staffordshire Combined Healthcare Trust (NSCHT) registered clinicans have an evidence base and clear process to follow which enables them to safety insert a NG tube.

What overarching policy the procedure links to?

This SOP should be read in conjuction with:

- Nutrition Policy Link
- Infection prevention and control policy.IPC 1
- Policy on the use and reduction of restrictive R01i
- Provision of enteral nutrition SOPs.

Which services of the trust does this apply to? *Where* is it in operation?

DIRECTORATE	Inpatients	Community	Locations
Community	x	x	Where applicable
Specialist Services	✓	x	All specialist inservice user services, including short breaks
Acute Services and Urgent Care	✓	x	All inservice user services
Primary Care	x	x	Where applicable
Corporate Services	x	x	NA

Who does the procedure apply to?

Registered healthcare professionals, such as Advanced Practice Nurse, Nurses and Dietitians who have received training in NG placement and are working in areas as identified above.

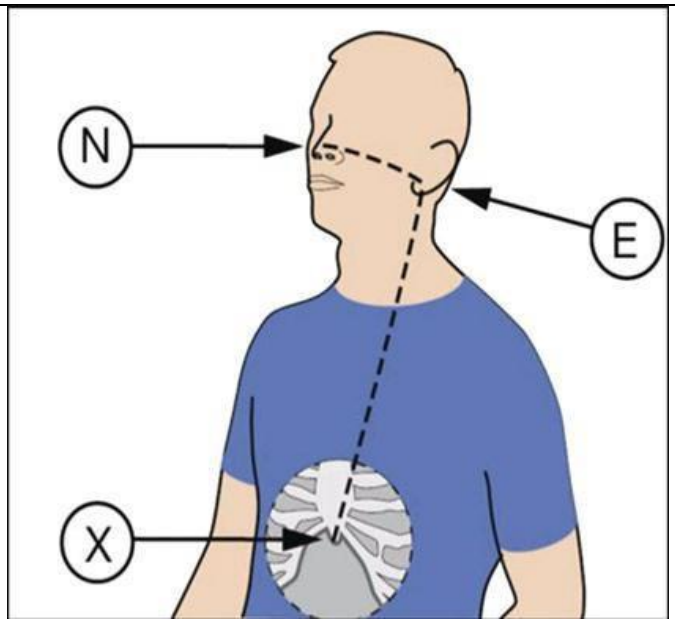
When should the procedure be applied?

The clinical rationale for NG placement will be discussed by the multi-disciplinary team, these conversations must include the Dietitian and if clinically indicated to include the Speech and Language Therapist. The provision for NG feeding is indicated for service users requiring short term enteral feeding (NICE guidance). Decisions for NG tube placement must follow the principles of least restrictive practice and be in the service user's best interests. Service users and their carers should be included in the decision making. Where service users do not have the capacity to consent, principles laid out in the Mental Capacity Act (2005) or Mental Health Act (1983) should be followed.

How to carry out this procedure (step step-by-step information)

This is taken directly from Royal Marsden Online Manual A video format of the procedure is available here: NG tube placement RMOM

Number	Step
1 – Pre procedure	1 - Service users preferences to be taken into consideration, and evidenced within the MDT care plan. 2 - Introduce yourself to the service user, explain and discuss the procedure with them. 3 - Arrange a signal by which the service user can communicate if they want the nurse to stop, for example by raising their hand. 4 – If the service user is able to stand safely procedure can be completed standing, if not assist the service user to sit in a semi-upright position in the bed or chair. Support the service user's head with pillows. *Note*: the head should not be tilted backwards or forwards 5 - NG is not classed as an Aerosol Generating Procedure as per National Infection Prevention and Control Manual. Contact IPC for further advice. 6- Select the appropriate distance mark on the tube by performing a NEX measurement: using the tube, measure the distance from the service user's nose to their earlobe plus the distance from the earlobe to the bottom of the xiphisternum.

	
2 Procedure	1- Wash hands with soap and water and assemble the equipment required. 2- Apply personal protective equipment (PPE). Minimum level required will be apron and gloves. 3 - Follow manufacturer's instructions to activate the lubricant on the tip of the tube, for example dip the end in tap water. 4- Check that the nostrils are patent by asking the service user to sniff with one nostril closed. Repeat with the other nostril. If this is reinstertion consider alternative nostril. 5- Insert the rounded end of the tube into the clearer nostril and slide it backwards and inwards along the floor of the nose to the nasopharynx. If any obstruction is felt, withdraw the tube and try again in a slightly different direction or use the other nostril. 6- As the tube passes down into the nasopharynx, unless swallowing is contraindicated, ask the service user to start swallowing and sipping water. If the service user is unable to drink safely, ask them to perform a dry swallow. 7- Advance the tube through the pharynx as the service user swallows until the predetermined mark has been reached (NEX measurement) at the opening of the nostril. If the service user shows signs of distress, for example any respiratory distress, remove the tube immediately. Do **not** flush any fluid or air down the nasogastric tube until the position has been checked. 8- Secure the tube to the nose with either adherent dressing tape or an adhesive nasogastric stabilisation/securing device. Alternatively, hypoallergenic tape can be applied to the cheek to secure the nasogastric tube. Ensure the nasogastric tube is not putting pressure on the nares.

3 Post procedure	1 - Measure the external (visible) part of the tube from the tip of the nose and record this and the NEX measurement in the care plan. 2- The guidewire/stylet should be removed following the manufacturer's guidelines; and disposed of in the sharps bin. 3- Check the position of the tube to confirm that it is in the stomach by using the following methods: **First-line test method**: • pH paper: aspirate 0.5–1 mL of stomach contents and test its pH on indicator strips. • When aspirating fluid for pH testing, wait at least 1 hour after a feed or medication has been administered (either orally or via the tube). • A pH level of between 1 and 5 is appropriate to proceed to feed through the tube. • If pH of 5.5 or above, unless previously agreed by MDT, do not proceed. Retest, if reading is still above 5.5 remove the NG tube and restart the procedure with a new tube. 4 – At this point continue with treatment plan e.g provide feed. 5 - Record the procedure in the electronic service user record.

Where do I go for further advice or information?

Problem solving tips and guidance can be found in the Royal Marsden online manual in table 8.14 and box 8.6 located on this link

Please see nurse in charge/ ward manager / Matron / site manager.

Please contact trust Lead Dietitian, Nic Rudd, Nicola.rudd@combined.nhs.uk

Training

Registered nursing staff will qualify with this proficiency. For registered who require further training or upskilling they will require simulated training and completion of competency assessment (see appendix 3).

Registered staff may have received this training as part of their professional course, where there is evidence to support this and competence, refreshing is not required. Staff may receive training in relation to this procedure, where it is identified in their induction, supervision or annual appraisal as part of the specific development needs for their role and responsibilities. You may be asked by your line manager to complete the training or competency assessment at any time should concerns be expressed about your competence.

All practitioners should remind themselves of their professional responsibilities under their relevant governing body and follow the SOP. Additional support and training can be provided where necessary, but it is the responsibility of each practitioner to assess their own competence, above and beyond the scope of this document.

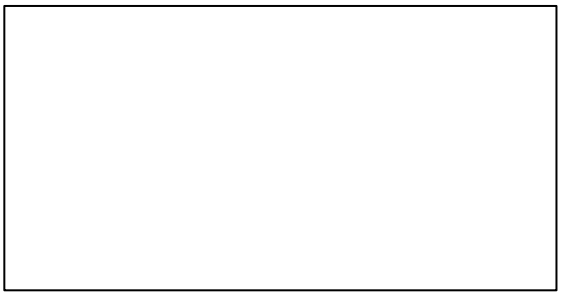
Please refer to the Trust's Mandatory & Risk Management Training Needs Analysis for further details on training requirements, target audiences and update frequencies.

Monitoring / Review of this Procedure
In the event of planned change in the process(es) described within this document or an incident involving the described process(es) within the review cycle, this SOP will be reviewed and revised as necessary to maintain its accuracy and effectiveness.

Equality Impact Assessment
Please refer to overarching policy

Data Protection Act and Freedom of Information Act
Please refer to overarching policy

Appendix 1: Nasogastric Tube Position Check



Date/Time	pH of aspirate	Marking at nose (cm)	Tube tape checked?	Nasal mucosa intact?	Name/signature of first checker	Name/signature of second checker

Appendix 2: Procedure Checklist

To be completed prior to start of procedure Patient identity confirmed ☐ Verbal consent from parent/carer ☐ Repassing of NG tube ☐ Clinical indication _____ Clinical indication for insertion documented ☐ Rationale for insertion explained to patient and parent/carer ☐ If no, please justify_____ Contraindications reviewed ☐ Procedure during core hours ☐ If no, please justify_____ Sedation required_____ Any known allergies_____ Operator trained in insertion ☐If no, operator supervised by trained operator ☐	Correct type/size of NG tube available ☐ All equipment available and in reach ☐ If appropriate, a STOP sign has been agreed ☐ Nose examined and nostril selected ☐ Staff name_____ Staff Signature_____ Date_____	**Patient Name** **NHS no.** **Date of birth:** **Sign out** Type of tube inserted_____ Brand of tube inserted_____ LOT number_____ Expiry date_____ Nose-Ear-Xiphisternum measurement _____cm Guide wire removed ☐ Nostril used L/R Aspirate obtained ☐ pH of aspirate NG tube secured appropriately ☐ Staff name_____ Staff signature_____ Date_____

Appendix 3

Competency Assessment for the management of Nasogastric tubes

Name of Professional					Name of assessor	
Designation of Professional					Designation of assessor	
	Assessment	**State what type of observation (Direct or Questioning)**	**Date**	**Signature**		
Date and signature of trainer for each assessment	1st Assessment				Reason for assessment (new to role/ annual review or incident management)	
	2nd Assessment					

Please note – each assessment includes at least 1 successful passing and feeding procedures. The first assessment will be signed off in simulation training.

Guidance for Professional

This assessment record is to document the above named professional has successfully been assessed by a competent Nasogastric trainer and has successfully completed the Nasogastric competency assessment. This above registered professional is now deemed competent to risk assess patients, to assess capacity and consent to this procedure, successfully pass a NG tube and maintain this, make a clinical decision regarding feeding and medication and to be able to complete all relevant documentation associated with NG tubes at NCSHT. The registered named professional above has also been assessed to be competent in dealing with any incidents associated with Nasogastric tubes at NSCHT.

This competency document is required for ***all professionals working*** *within NSCHT who are responsible for NG tube management. You may be asked by your line manager to repeat this assessment at any time should concerns be expressed about your competence.*

All practitioners should remind themselves of their professional responsibilities under their relevant governing body and follow the SOP. Additional support and training can be provided where necessary, but it is the responsibility of each practitioner to assess their own competence, above and beyond the scope of this document.

You are also reminded to keep up to date with evidence-based practice from **the Royal Marsden Manual of clinical and cancer nursing procedures** (accessible via CAT) and Medical Emergencies in Eating Disorder: Guidance on recognition and management (MEED, 2023)

Section 1 –Risk assessment and indicators for using a NG tube

Criteria that must be met in order for assessor to sign off the registered professional as competent	Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)						
		1st Assessment			2nd Assessment		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
1. Must have attended the 'NG Training' session	Date attended theory session.						
2. **Have good knowledge of anatomy and physiology and risks associated with using a NG tube**. (Test from training)							
3. **Be aware of any risks presenting with the person**– i.e. dehydration, risk of fainting, physically unstable, allergy status, infection risk markers, aggression towards staff, risk of using this intervention and if you need a team of people to support. Be able to explain how to minimise each risk.							
4. Show an understanding and explain why NG tubes are used							
5. **Be aware of current NG Standard Operating Procedure, Royal Marsden Manual and MEED guidance (2023).**							

Section 2 – Infection Control and Incident Reporting

Criteria that must be met in order for assessor to sign off the registered professional as competent	Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)						
		1st Assessment			2nd Assessment		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
1. **Demonstrate effective handwashing technique following current policy** (direct observation)							
2. **Explain and show the use of PPE equipment** (gloves, aprons, mask)							
3. Explain the incident / accident procedures (where appropriate) **Incident –** manage the incident then complete an Ulysess, document on EPR, inform team and parents/carers.							
4. **Explain how to handle leaks, spillages or broken equipment**							
5. Explain the procedure of disposing of waste including clinical waste procedure.							

Section 3 – Equipment and Environment

Criteria that must be met in order for assessor to sign off the registered professional	Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)						
		1st Assessment			2nd Assessment		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
1. **Explain the environment in which NG tubes are passed and why each one would be suitable or required** (i.e., room, chair, restraint, safety pod)							
2. **Equipment** needed to pass a NG tube and use this - **PPE –** gloves, apron, mask - **Sterile NG tube –** check expiry date, guide wire will move and size for patient. - **Dressing to secure NG tube –** check allergy status - **Sterile 60ml syringes –** separate syringes for aspirate, flush, feed and medication - **PH indicator paper –** cannot feed over 5.5 PH - **Water for patients to drink during procedure (when clinically appropriate)** - **Water to flush tube, feed and medication if required –** see							

individual plan for each patient. - **Clinical waste bin (yellow bag) –** for all equipment that has come into contact with aspirate or NG tube							

Section 4- Capacity and Consent

Criteria that must be met in order for assessor to sign off the registered professional as competent	Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)						
		1st Assessment			2nd Assessment		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
1. Have a good understanding of capacity and consent. Explain how you assess a patient as having capacity to consent to this procedure. **Is the person able to –** **1) Understand the information relevant to the decision** **2) Retain that information** **3) Use or weigh that information as part of the process of making the decision** **4) Communicates their decision (by any means)** **If a patient fails any one of these, they lack capacity**							
2. Explain the difference in patients over 16 years and under 16 years and how this effects capacity? **Over 16 - Adult presumed** to have capacity until it is deemed, they do not. Parents/ Carers should still be consulted but do not have to agree. **Under 16 -** can still have the capacity to consent but parents must							

consent to the procedure							
Criteria that must be met in order for assessor to sign off the registered professional as competent	**Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)**						
		1st Assessment			**2nd Assessment**		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
3. Explain the difference between formal and informal patients and how this effects treatment. **Informal –** must gain consent and have the right to refuse. **Mental Health Act** – must also try and gain consent but they may not have the right to refuse but this must be agreed with their Responsible Clinician and a plan to be in place.							
4. Under 16 - Parents consenting to procedure – parents must always be informed of the decision to use a NG tube and the rational for this. Parents who have a child who is under 16 years old must consent to the procedure. **Children 16 years and over** - staff do not have to gain consent from parents if the child has capacity to consent, but it is best practice to gain consent.	**(only to be assessed for CAMHS practitioners)**						
5. Explain how you document consent (patients EPR)							
6. What to do if an informal patient withdraws consent? (stop							

immediately, offer support, document, handover to team and discussion future care management) 7. **What to do if a patient under the MHA withdraws consent?** (this should be documented and contingency plans included within the plan of care and reviewed prior to procedure)							

Section 5 – Preparation of environment and equipment for passing a NG tube

Criteria that must be met in order for assessor to sign off the registered professional as competent	Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)						
		1st Assessment			2nd Assessment		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
1. Confirm the clinic or suitable room is available for this procedure to go ahead (either passing a NG tube or feeding)							
2. W your hands as per current policy and check your hands for any broken skin and cover with dressing if required.							
3. Put on correct PPE equipment – gloves, apron and mask if required.							
4. Gather and check all equipment, selecting correct NG size and check that equipment is in date and not damaged. Prepare the NG tube by checking the guide wire will move easily and there is no damage to the NG tube **(when handling a NG tube remember that this is a sterile piece of equipment so you must wear gloves when checking the NG tube)**							
5. Ensure all your equipment is ready including water for the patient, vomit bowls and a clinical waste bin.							
6. Review the plan of care feeding regime and ensure you are aware of any risk, previous concerns and contingency plan.							

Section 6 – Approach and communication

Criteria that must be met in order for assessor to sign off the registered professional as competent	Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)						
		1st Assessment			2nd Assessment		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
1. Introduce yourself and other staff to the patient and explain rationale for the procedure (this is an invasive and uncomfortable procedure, therefore emotional and physical reassurance and support will be provided)							
2. Check the patient's identification by confirming name and DOB and allergy status.							
3. Explain the procedure in a manner and language that is suitable for your patient and allows them time to ask any questions.							

Section 7 –Passing a NG tube

Criteria that must be met in order for assessor to sign off the registered professional as competent	Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)						
		1st Assessment			2nd Assessment		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
1. Check that the patient is steady and in a comfortable position, they must have their head straight and body steady. If you are using restraint, then you must ensure that the staff holding the patient are aware of how the patient must be positioned whilst you are passing the NG tube.							
2. Assess which nostril will be most suitable (i.e. not blocked or has previous trauma). If there is no obvious difference, ask which nostril they would prefer the NG tube to be passed in.							
3. Explain the procedure to them and that you will ask them to swallow when the NG tube is being passed over the bridge of the nose. There may be times where it is **clinically appropriate** for the patients to be offered water when NG tube is passed.							
4. Re-check they are in the correct position or that the staff using a clinical hold are in the correct position for the procedure to take place.							

Section 7 – passing a NG tube continued

Criteria that must be met in order for assessor to sign off the registered professional as competent	Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)						
		1st Assessment			2nd Assessment		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
5. Check the NG tube guide wire is in place and secured, when removing from packet.							
6. Complete Nose, Ear and Xiphisternum (NEX) management (refer to SOP)							
7. Follow manufacturer's instructions to activate the lubricant on the tip of the tube, for example dip the end in tap water.							
8. Using a dart motion, pass the NG tube along the bottom of the nostril. **Do not aim the NG tube towards the roof of the nostril**							
9. Once you feel slight tension, advise the patient to swallow to carry NG tube over nasopharynx. Ask patient to continue to swallow to ensure that the epiglottis is closed to allow NG tube pass through the hypopharynx and down the oesophagus into the opening of the stomach. **If at any point the patient starts coughing or is unable to breathe, stop and remove the NG tube immediately as this may have passed into the windpipe and into their lungs.**							

Criteria that must be met in order for assessor to sign off the registered professional as competent	Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)						
		1st Assessment			2nd Assessment		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
10. Once NEX measurement is reached, remove guide wire. Before securing the NG tube, ask second staff member to hold NG tube to prevent movement whilst you obtain aspirate.							
11. Once you have obtained an aspirate PH of below 5.5, then secure the NG tube to the patients face with a suitable dressing **(be aware of any allergies). You must always flush a NG tube with at least 30 mls of tap water after any use or as per care plan.**							
12. Once the NG tube is secure and has been flushed, you may now administer medication or fluids, as per their feeding regime.							
13. **Always remember that you must check each time you use an NG tube the position and the PH.** Without confirming the placement of a NG tube, you cannot administer any via the tube.							

Section 8 – Administering medication and fluids via NG tube

Criteria that must be met in order for assessor to sign off the registered professional as competent	Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)						
		1st Assessment			2nd Assessment		
	Methodology ofCompetence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
1. Each time you use the NG tube you must check the length and position of the tube via checking the number on the NG tube.							
2. Each time you use an NG tube you must check PH reading. Attach a new sterile syringe to the NG port. Pull back gently to obtain the aspirate. **Without the PH reading you cannot proceed to use the NG tube, as it may be in the lungs and you then can cause aspirate pneumonia and potentially death. YOU CANNOT FEED ON A PH ABOVE 5.5.** Once this is confirmed dispose of equipment in clinical waste.							
3. Once the correct PH is confirmed you must now flush the tube with a new sterile syringe and tap water that is a room temperature. The minimum water that must be used is 30mls, but you must follow the prescribed feeding regime for each patient.							
4. Use a further new sterile syringe to administer feed. You must do							

this at a consistent and steady pace/ or by gravity feeding. Do not force the feed through the tube as you risk rupturing the NG and causing trauma to the patient's stomach.							
Criteria that must be met in order for assessor to sign off the registered professional as competent	**Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)**						
		1st Assessment			**2nd Assessment**		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
5. Observe the patient throughout the feed and check for any physical deterioration, vomiting or NG displacement. If any of these occur, you must stop immediately and assess the situation. If the tube has moved, you must gain a further PH below 5.5 before continuing. If any medical concerns arise, seek guidance.							
6. **For Restraint:** Observe movement of NG tube, should this be greater than 3-4cm, stop procedure. Anything under movement of 3-4cms continue with feed.							
7. Once the feed is completed, use a final flush (tap water) as stated on the feeding regime and then ensure the end of the NG tube is clean and the connector is closed.							
8. Document the feed on the patient's EPR.							

9. To maintain the NG tube for as long as possible you must ensure that the NG tube is kept clean, handled with care and the patients do not interfere with the NG tube or ports. **NG TUBE MUST BE FLUSHED AT LEAST TWICE A DAY EVEN IF NOT IN USE.**							
10. Encourage a sitting/ or up right position for a minimum of one hour post feed.							

Section 9 – Risks of displacement and PH issues

Criteria that must be met in order for assessor to sign off the registered professional as competent	Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)						
		1st Assessment			2nd Assessment		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
1. It is imperative that before each and every feed the tube's placement is checked, and correct PH is seen and documented. NG tubes can be displaced with coughing, reflux, vomiting, tampering.							
2. If tube has been displaced, it is to be removed and repassed. **Never feed on an incorrect PH or displaced tube.** The tube should be checked after a patient vomits, if external length of tube changes or if there is ever a concern it is not in the stomach.							
3. You MUST NEVER put fluids or medication down a NG tube if you have not obtained a PH 5 or below. If you are struggling to get an aspirate, ask the patient to change position, stand, shake their body a little and lye on their left side. Ask them to drink some water, if clinically appropriate to do so. If this continues to produce no aspirate or PH over 5 you will have replace the NG tube until you get the correct aspirate. If unable to successfully pass the second NG tube and obtain aspirate, seek guidance from MDT.							

Section 10 – Removal of a NG tube

Criteria that must be met in order for assessor to sign off the registered professional as competent	Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)						
		1st Assessment			2nd Assessment		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
1. The removal of the NG tube needs to be either – with agreement from the patient's team now they are meeting their nutritional or medication needs or if the NG tube is blocked, broken or needs to be changed due to continued use (please see manufacturing guidance for maximum duration the NG tube can be in situ for).							
2. Explain why this is being removed and or changed for another NG tube.							
3. Don the correct PPE equipment on and gather some tissue							
4. Ask the patient to remove the dressing of the NG tube or do this for them if they wish. Keep hold of the NG tube whilst you do this.							
5. Place the tissue at the base of the nostril and pull the NG tube out in a consistent and gentle manner. Gather the NG tube into the tissue and dispose of the clinical waste bin.							

Section 11 – Removal of a NG tube continued

Criteria that must be met in order for assessor to sign off the registered professional as competent	Assessors must complete one assessment in simulation and record the assessment method (2nd Assessment only to be in clinical practice)						
		1st Assessment			2nd Assessment		
	Methodology of Competence (Q & A or Observation)	Yes	No	Assessor initials	Yes	No	Assessor initials
6. **ALL NG TUBES ARE ONCE ONLY USE.** You cannot reinsert them under any circumstances.							
7. Ask the patient if they want to wipe their nose and observe for any bleeding.							
8. Dispose of your PPE in the clinical waste bin and wash your hands.							
9. Document the removal of the NG tube on the patient's EPR.							

Signature of 1st Assessor:	**Signature of 2nd Assessor:**
Full name / designation:	**Full name / designation:**
Date:	**Date:**
Signed Trainee:	**Signed Trainee:**
Full name / designation:	**Full name / designation:**
Date:	**Date:**