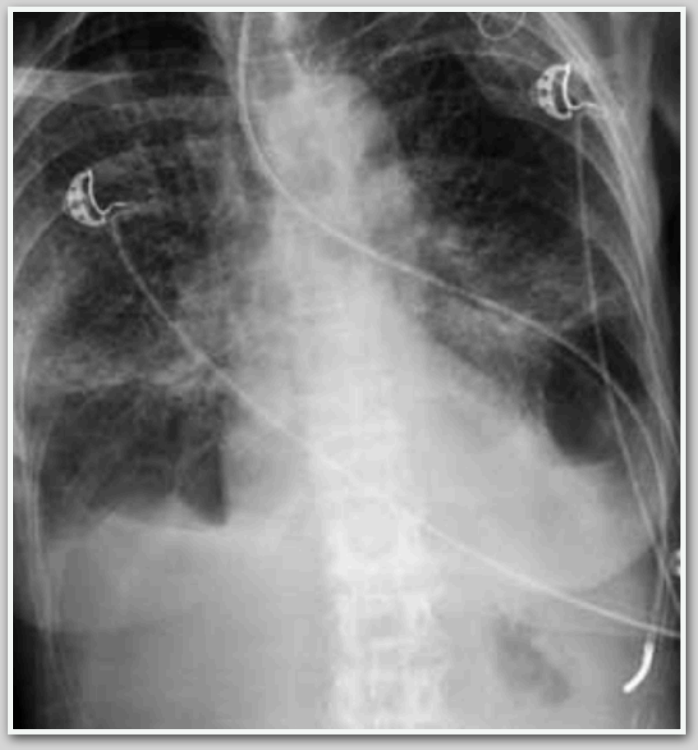
ACCU KIT OF THE WEEK

THE ROYAL LONDON HOSPITAL

Nasogastric Feeding Tubes

JM February 2021



What's wrong here?

There is an NG Tube that sits in the respiratory tract. Although the tip sits 'below the diaphragm' it follows the path of the left main bronchus and sits in the pleural space in the left hemithorax.

How do you confirm NGT position?

The tip of the NGT must sit in the stomach. First-line is to check pH of aspirate- it must be 5 or less. If this is impossible or the result is equivocal, XRay is required. Barts have their own flow-diagram based on national guidelines. ACCU are finalising a training package to allow senior doctors to interpret XRays for NGT. At present, we need all NGT XRays to be reported.

How do you insert an NGT?

Consent or proceed on best interests.
Wear gloves and an apron.
Take a NEX measurement (nose > earlobe > xiphisternum).
Insert along the floor of the nose until visible in the pharynx.
Continue to advance until at the predicted measurement at the nostril- Try to avoid using a laryngoscope to pass an NGT as this can cause additional trauma to the oropharynx and airway.
Secure in position and record depth.
Attempt confirmation with pH testing/ proceed to XRay.
If confirmed, this must be recorded and time-stamped in the notes.

The contraindications?

Complex base of skull fractures (place Oro-gastric if intubated). Recent nasal surgery. Inability to nurse safely at 30 degrees head up during feeding.

Hazards of NGT use?

Unrecognised misplacement and feeding into respiratory tract (a never event).
Aspiration of feed, even if correctly positioned (check risk profile of patient and ward setting).
Discomfort and distress during insertion.
Traumatic insertion including epistaxis.
Local complications- rhinitis, erosion of GIT.
The NG tubes are quite rigid and can cause perforation of small airways and pneumothorax if misplaced in the lung.

What's a Never Event?

NHS England keeps a list of serious incidents that should be wholly preventable. They must be reported centrally and are used to keep track of the safety-record of an organisation.

Examples of other relevant Never Events in ACCU

Retained guide-wire post CVC insertion
Insulin administration errors
Wrong route medication administration
Mis-selection of strong potassium solution
ABO incompatible transfusion