Whittington Health NHS

Whittington Hospital

NASOGASTRIC TUBE FEEDING FOR ADULTS

Subject:	Nasogastric tube feeding for adults
Policy Number	N/A
Ratified By:	Clinical Guidelines Committee
Date Ratified:	December 2011 (v 6.0) reviewed December 2015
Version:	8.0
Policy Executive Owner:	Dr C Murdoch, ICAM Divisional Director
Designation of Author:	Ann McMulkin (Nutrition Nurse Specialist);Dr Robert Katz (Consultant Radiologist)
Name of Assurance Committee:	As above
Date Re-Issued:	December 2015
Review Date:	3 years hence
Target Audience:	All clinical staff undertaking nasogastric feeding
Key Words:	Nasogastric feeding, nasogastric tube, nutrition, pH indicator strips, aspirate, X-ray interpretation and confirmation

Version Control Sheet

Revision Chronology:		
Version Number	**Effective date**	**Reason for Change**
1	December 2002	Guidance on Insertion of fine bore NG tube devised
2	February 2004	Incorporated clinical indications/ contraindications for NG feeding
3	June 2006	Local response to NPSA Alert/2005/05: Reducing the harm caused by misplaced nasogastric feeding tubes
4	April 2010	-Local response to NPSA Alert NPSA/2007/19: Promoting safer measurement and administration of liquid medicines via oral and other enteral routes. -Incorporated Nasogastric tube feeding for the adult patient Core care plan
5	November 2011	Incorporated guidance for supporting safe x-ray interpretation as per NPSA Alert/2011/PSA002
6	September 2012	Incorporated guidance as per NPSA/2012/RRR001
7	November 2014	Scheduled review
8	December 2015	Incorporated amendments from SI Action Plan

Content of this Guidance:

- Nasogastric feeding for adults ***(Section 1)***
- Insertion of a fine bore nasogastric feeding tube/notes on large bore/Ryles tubes – Procedure for adults **(*Section 2)***
- Nasogastric feeding tubes in adults – Ongoing management ***(Section 3)***
- X-ray requesting and confirmation of nasogastric tube **(Section 4)**
- Confirming correct position of nasogastric feeding tubes in adults***(Appendix 1)***
- Nasogastric tubes: X-ray interpretation aid **(*Appendix 2*)**
- Nasogastric tube feeding for the adult patient – Core care plan ***(Appendix 3)***

Criteria for use:

Nasogastric feeding tubes are used to provide liquid nutrition to adult patients who have swallowing or feeding difficulties. They may be used to supplement an inadequate oral diet or to provide total nutrition to patients who are unable to consume food orally. In addition, tubes may be used for the administration of medication for patients who have an abnormal swallow.

This guideline refers to nasogastric tube management of adult inpatients only.

Background information:

Nasogastric tube feeding is commonly performed in adult patients without incident. However there is a small risk that the feeding tube can be misplaced into the lungs during insertion, or move out of the stomach at a later stage. Following reports of patient death and harm caused by misplaced nasogastric feeding tubes, the **National Patient Safety Agency (NPSA): issued alerts: NPSA 2005 and NPSA/2011/PSA002 stipulating the use of pH indicator strips (**specified to be CE marked 2011**) to confirm the correct position of the tube. pH testing** is used as the **first line test method.** Since the NPSA alert 2005 there has been a further 21 deaths and 79 cases of harm reported to the National Reporting and Learning System (NRLS). The main causal factor leading to harm from misplaced nasogastric tubes was **misinterpretation of x-rays.** Information to support safe x-ray interpretation is included in this guideline.

In 2009 feeding into the lung from a missed placed nasogastric tube became a Never Event in England. Evidence from the Never Event reports suggests there are issues with x-ray interpretation at all times, and there may be increased risks from nasogastric placement or x-ray checking at night.

Insertion of Nasogastric tubes for the purpose of feeding and/or commencement of feeding should only occur during usual working hours (9-5pm seven days a week) unless clinically urgent.

Section 1: Clinical indications for nasogastric feeding

Before a decision is made to insert a nasogastric tube, an assessment should be undertaken to identify if nasogastric feeding is appropriate for the patient, and the rationale for any decisions should be recorded in the patient's notes.

Clinical indications for nasogastric feeding (This is not a definitive list):

- Abnormal swallow may be considered in the following: unconscious, cerebrovascular accident (CVA)
- Unable to meet nutritional requirements orally
- Increased requirements e.g. pressure sores
- Anorexia e.g. oncology patients, depression
- Neurological disorder e.g. motor neurone disease
- Chronic malnutrition

Contraindications to Nasogastric Feeding
Please discuss with your ward Dietitian*:*

- Gastrointestinal obstruction
- Oesophageal /gastric fistulas
- Persistent poor gastric emptying
- Peritonitis
- Intractable vomiting
- Acute inflammatory bowel disease (requiring complete bowel rest)
- Basal skull fracture

Section 2: Procedure for insertion of a fine bore nasogastric feeding tube

ACTION	RATIONALE
Wash hands	To reduce the risk of cross infection and comply with hospital hand hygiene policy
Explain the procedure to the patient	To ensure the patient understands the procedure and gives valid consent
Help conscious patients adopt a comfortable semi-recumbent position. Support the patient's head with pillows. The head should not be tilted back	To allow for easy passage of the tube. This reduces the risk of tracheal intubation and ensures that the epiglottis is not obstructing the oesophagus.
Arrange a signal such as raising the hand	To enable the patient to request the procedure to proceed more slowly or stop

Ensure correct length of tube is passed	Too much tube passed results in the tube kinking which may cause difficulty when removing the guide-wire Too little tube passed risks the tube tip being positioned incorrectly in the oesophagus
The tube length should be estimated before insertion using the **NEX** measurement (place exit port of tube at tip of nose. extend tube to earlobe, then to xiphisternum. Document the external length of the tube at the nose on the fluid chart.	To determine the length of tube which needs to be introduced in order for the tip to be correctly positioned in the stomach
Lubricate the tip of the tube with sterile water	To assist its passage
Check the patient's nostrils	To determine if any nasal polyps or a deviated septum
If the patient is able to co-operate request that when the tip is felt in oropharynx (throat) he/she swallows, tilting the chin down slightly at the same time	Helps the tip pass into the oesophagus.
Advance the tube forward, maintaining a calm manner and encourage the patient to take slow even breaths	Assists relaxation and avoids laryngeal spasm

Confirmation of tube position after initial insertion:

NOTHING should be introduced down the nasogastric tube and DO NOT FLUSH the tube before gastric placement has been confirmed.
Internal guide wires should NOT be lubricated before gastric placement has been confirmed.

ACTION	RATIONALE
If a guide-wire is used, keep in position, attach a syringe and aspirate a specimen of stomach contents using a 50ml enteral syringe.	Avoids the need for X-ray reduces radiation exposure. Avoids delay in commencing feed
Stomach contents are acidic. Test aspirate and define the pH with CE marked pH **indicator strips.** (the pH must be 1.0 and 5.0 before the tube is used)	To check/ confirm the correct position of the nasogastric tube

If aspirate cannot be obtained or if the pH range is difficult to define, and you have followed the guidance (Appendix 1) discuss with nurse in charge, X-ray may be required to confirm the position of the tube. **NB. In patients with abnormal anatomy aspiration may be difficult. Each patient must be individually assessed and appropriate clinical plan devised.**	To ensure correct placement of tube
Once tube confirmed in correct position (by one of the above methods) remove guide-wire if still in place	To permit the delivery of feed
If a guidewire is used it must never be reinserted unless the tube has first been withdrawn from the patient	If the tube is kinked or coiled, the wire may perforate the tube and damage adjacent organs
Use a soft adhesive tape to secure the tube. Document the external length of the tube at the nose on the fluid chart	Rigid tapes may irritate the soft skin of the face Additional safety check for tube displacement
Record the procedure and the technique used to confirm the position of the tube in the notes. Place the completed NG sticker (comes with the tube package) in the notes.	For audit purposes and in the event of a query.
If at any time or following the procedure signs of respiratory distress occur the tube must be withdrawn.	The tip may have entered the respiratory system.

Notes on the use of wide bore feeding tubes:

Follow the guidance as for insertion of a fine bore nasogastric feeding tube procedure for adults. Please note points referring to guidewire do not apply to a wide bore feeding tube.

- Large bore drainage tubes i.e. **Ryles** tubes which are not NPSA compliant **MUST NOT** be used for administration of any feed, liquid or medication
- Ryles tubes do not have a guidewire and are not radiopaque
- Ryles tubes are made of plastic and have a potential to produce an acid which may cause nasal erosion and necrosis therefore it is advisable to carry out individual patient risk assessment daily

- Large bore tubes can be used for drainage and administration of feed, liquid or medication but **MUST** have the word enteral on the tube and be NPSA compliant

Section 3: Ongoing management of nasogastric feeding tubes

Carry out individual risk assessment prior to tube feeding:

Prior to each feeding episode, a risk assessment needs to be carried out by a competent person. A decision needs to be made that balances the risks with the need to feed. Patients who are comatose or semi-comatose, have swallowing dysfunction or recurrent retching or vomiting, have higher risk of placement error or migration of the tube, whereas patients on antacid medication are more likely to have pH levels of 6 and above. However if the guideline is followed as per Appendix 1, it is still possible to obtain a pH level of 1.0 to 5.0.

External markings prior to **each** use **MUST** match initial record of tube length at the nose and documented on the fluid chart. Actions to reduce risk and the rationale behind these actions should be documented prior to the commencement of feeding. This information will support you in making correct clinical decisions.

Checking the tube position:

The tube position **must be** checked and documented on the fluid chart:

- Following initial insertion and place the completed sticker in the notes
- **Immediately** before the first bottle/feed/flushes for each day if patient on continuous feeding regimen
- **Immediately** before each bolus episode of feed if patient on bolus feeding regimen
- **Immediately** before administering each episode of medication (if tube for medication only)
- Following episodes of suctioning (catheter going beyond the vocal cords), vomiting, retching or coughing (note the absence of coughing does not rule out misplacement or migration)

Following any concern or evidence of tube displacement for example:

- Loose tape where tube secured
- Visible tube length appears longer/shorter
- Concern about a patient who has been pulling at the tube or has removed mittens. Particular vigilance is required when caring for patients with delirium.

If a tube is repositioned for any reason the tube position **must** be rechecked

Procedure for confirming the correct position of nasogastric feeding tubes in adults ~ ongoing management:

ACTION	RATIONALE
Check if the patient is on medication that may increase the pH level of the gastric contents	Medication that could increase the pH level of gastric contents are: antacids, H2 antagonists and proton pump inhibitors. For these patients the initial risk assessment needs to identify actions that staff should take and document them in the care plan.
Check for signs of tube displacement	Document the external length of the tube initially and check external marking at the nose prior to **each** feeding/use will help to determine if the tube has moved.
Sufficient aspirate (2-3 drops) obtained	2-3 drops of aspirate will cover adequately the reagent panel of the pH testing strip. Allow ten to sixty seconds for any colour change.
Aspirate pH is 1.0 to 5.0	Commence feed/use tube. There are no known reports of pulmonary aspirates at or below this figure. The range of pH 1.0 to 5. 0 balances the risk between increasing the potential problems for clinical staff e.g. removing tubes that are actually in the stomach, increased use of X-ray.
Aspirate is pH 5.5 or above	**DO NOT FEED/USE.** Possible bronchial secretions. The initial risk assessment should identify actions for staff to take in this scenario for each patient. Document actions in the care plan. If there is any doubt about the tube position the tube should not be used – seek advice. **NOTHING** should be introduced down the nasogastric tube and **DO NOT FLUSH** the tube before gastric placement has been confirmed.
Wait for 15-30 minutes before re-aspirating to check pH level	Failure to obtain aspirate below pH of 5.0 may be due to dilution of gastric acid by enteral feed. Waiting up to 15-30 minutes will allow time for the stomach to empty and the pH to fall. The time interval will depend on the clinical need of each patient.
Problems obtaining aspirate? If possible turn patient onto their **left** side	This will allow the tip of the tube to enter the gastric fluid pool
Advance or withdraw the tube by 10-20cms Wait for 15-30 minutes before re-aspirating to check pH level	Advancing the tube may allow it to pass into the stomach if it is in the oesophagus. Withdrawing it may allow it to pass back into the stomach if it is in the jejunum
Discuss with nurse in charge. Consider X-ray	X-ray should not be used routinely in order to avoid increased exposure to radiation, loss of feeding time for the patient

Section 4: X-ray requesting and confirmation of nasogastric tube position

X-ray is used only as a **second line test** when no aspirate can be obtained or pH indicator strip has failed to confirm the position of the nasogastric tube. Following discussion with the nurse in charge, the following steps must then be taken:

- The X-ray is requested via Anglia Ice using the **NGT request form**. (Do not use a chest x-ray request form). It must clearly state the purpose of the x-ray is to establish the position of the nasogastric tube

- It is the radiographer's responsibility to ensure the nasogastric tube tip can be seen clearly on the x-ray to be used to confirm tube position

- If the patient is MRSA positive the Radiology Department will aim to do the check x-ray as soon as possible i.e. if the form is received in the morning, the x-ray should be done at the end of the morning session

- A trained nurse must accompany the patient to the x-ray department to provide the required skills to manipulate/reinsert the tube if required

- The nurse should contact the relevant Doctor to interpret and confirm the tube position **before** the patient leaves the x-ray department

- Level FY1 is authorised to check a radiologist report, but they are not authorised to interpret a check x-ray for nasogastric tube placement

- It is a requirement that **only level FY2 and above** interprets the current x-ray. The **tip** of the nasogastric tube must be visualised **(Appendix 3)**

- If there is difficulty in interpretation the advice of a Radiologist should be sought (Radiologist i.e. hot seat available 09.30-16.30 daily)

- Any nasogastric tubes identified to be in the lung should be immediately removed whether in the x-ray department or clinical area

Documentation following X-ray should include:

The relevant section of the request form needs to be completed by Doctor/Radiologist who confirmed the position of the nasogastric tube. This person must be evidenced as competent to do so. This form must be filed in the patient's notes

Level FY2 and above should ensure they have completed the eModule training tool for x-ray interpretation of nasogastric tube position via the ESR NHS e-learning portal which will automatically update their ESR record. This mandatory eModule needs to be completed within two weeks of joining the Whittington Hospital.

Doctors transferring from other Trusts who have already completed the module and can provide evidence of their completion should email this evidence to whh-tr.learninganddevelopment@nhs.net to avoid having to repeat the module

Confirmation that any x-ray viewed was the most current x-ray for the correct patient and clear written instructions as to required actions i.e. safe to use for administration of any liquids via the tube

All nasogastric tubes will be regarded as high priority and reported on by a Radiologist within 24hours

The Radiologist will contact the referring team if any nasogastric tube is perceived to be in the wrong place

Appendix 1: Confirming the correct position of nasogastric feeding tubes in adults - Ongoing management

1. Check if on acid inhibiting medication
2. Check for signs of tube displacement, measure external tube length at nose
3. Reposition or re-pass tube if required
4. Aspirate using a 50ml enteral syringe and gentle suction
5. **NOTHING** should be introduced down the nasogastric tube and **DO NOT FLUSH** the tube before gastric placement has been confirmed

Aspirate Obtained

Aspirate obtained (2-3 drops)
↓
Test on CE marked pH strip
↓
pH 1.0 to 5.0 or below
↓
Proceed to feed/use

pH 5.5 or above

DO NOT FEED/USE
↓
Leave for up to15-30 minutes
↓
Try aspirating again
↓
pH 1.0 to 5.0 → pH 5.5 or above
↓ ↓
Proceed to feed/use **DO NOT FEED/USE**
↓
Call nurse in charge for advice
↓
Consider replacement/re-passing of tube/and or check position by X-ray

CAUTION: If there is ANY query about position and/or the clarity of the colour change on the pH strip then the tube should not be used.

Problems Obtaining Aspirate

Aspirate not obtained
↓
DO NOT FEED/USE
↓
If possible, turn patient onto their left side
↓
Advance/withdraw tube by 10-20cm
↓
Wait for 15-30 minutes and try aspirating again
↓
Aspirate not obtained → Aspirate obtained (2-3 drops)
↓ ↓
DO NOT FEED/USE Test on CE marked pH strips
↓ ↓
Call for advice pH 1.0 to 5.0 or below
↓ ↓
↓ Proceed to feed
Consider replacement/re-passing of tube and/or checking position by X-ray

Alert

Patient Safety Alert

NPSA/2011/PSA002
10 March 2011

Nasogastric tubes: x-ray interpretation aid

a. Is nasogastric tube feeding the right decision for this patient?
b. Is this the right time to place the nasogastric tube and is the appropriate equipment available?
c. Is there sufficient knowledge/expertise available at this time to test for safe placement of the nasogastric tube?

To confirm gastric position of the nasogastric tube, ask:

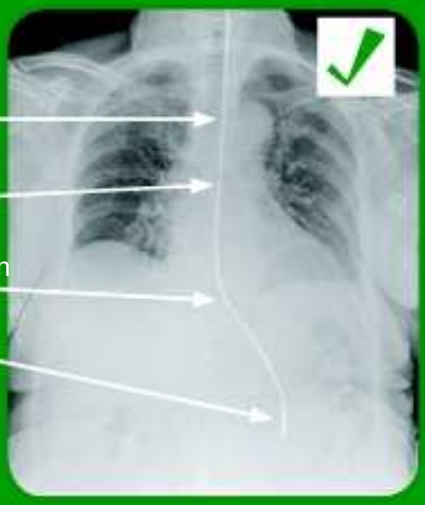
Does the tube path follow the oesophagus/avoid the contours of the bronchi?

Does the tube clearly bisect the carina or the bronchi?

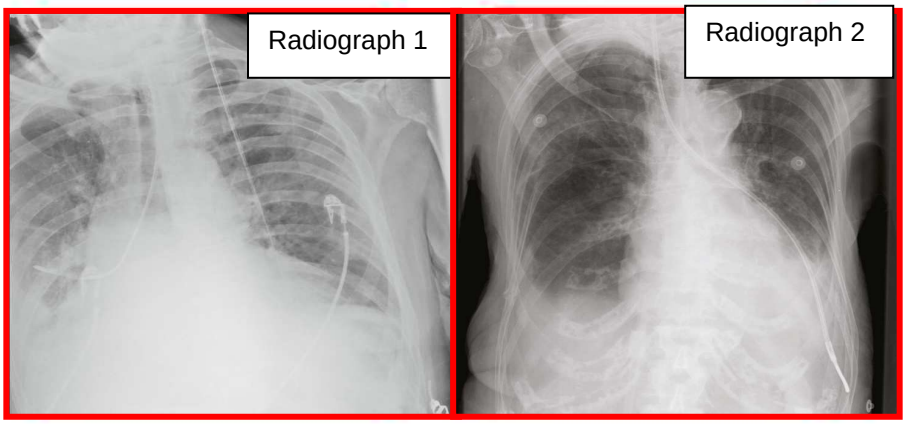
Does it cross the diaphragm in the midline?

Is the tip clearly visible below the left hemi-diaphragm?

Proceed to feed only if all criteria are met. If in any doubt repeat x-ray or call for senior help.



Below are two examples where the nasogastric tube has been incorrectly identified as being in the stomach:



Radiograph 1 shows the tip of the nasogastric tube above the diaphragm and on the right-hand side of the thorax. The presence of ECG leads make interpretation of the radiograph more difficult.

Radiograph 2 shows the tip of the nasogastric tube apparently below the left hemi diaphragm but the tube clearly follows the contours of the left bronchus. In fact, the tube is positioned in the left lower lobe of the lung.

X-rays must always be interpreted by someone assessed as competent to do so, and the decision to feed a patient must be documented in the patient's medical notes, dated, timed and signed by that person.

Whittington Health NHS

NASOGASTRIC TUBE FEEDING – NURSING CORE CARE PLAN (adult)

NAME: **HOSP No:** **WARD:**

PROBLEM NUMBER:

Date & Time	PATIENT PROBLEM/ NEED	RN SIGNATURE	Review Date
	…….. requires a tube to provide liquid		
	nutrition / medication / fluid due to swallowing or feeding difficulties.		
	Potential risk of tube misplacement and development of aspiration.		
	Potential risk of nasal irritation.		
Date & Time	**GOAL**	**RN SIGNATURE**	**Review Date**
	To ensure correct method is used to insert tube.		
	To ensure correct method is used in confirming position of tube.		
	To ensure the safe and effective delivery of nutrition/ medication/ fluids.		
Date & Time	**PLANNED NURSING INTERVENTIONS**	**RN SIGNATURE**	**Review Date**
	a. Introduce yourself - initiate patient /nurse relationship – reassure patient		
	b. For additional information refer to Whittington Hospital NHS Trust		
	guideline available on the intranet under Clinical Nutrition Service:		
	Nasogastric tube feeding for adults		
	c. Check the tube position by obtaining aspirate using a 50ml enteral		
	syringe and placing the aspirate on a CE marked pH indicator strip.		
	The pH MUST be 1.0 to 5.0 before the tube is used		
	Document the pH of the aspirate and external length of tube at nose on the		
	fluid chart at least once daily. In addition see below:		
	e. Tube position MUST be checked or rechecked:		
	i. Following initial tube insertion and place completed NG sticker in the notes		
	ii. Immediately before first bag/feed/flushes for each day if on continuous feed iii. Immediately before each bolus episode of feed if on bolus feeding regimen		
	iv. Immediately before administering each episode of medication (if the tube is for medication only)		
	Following episodes of suctioning(catheter going beyond the vocal cords)		
	vomiting, retching or coughing (**N.B**. absence of coughing does not rule out		
	misplacement or migration)		
	Following evidence of tube displacement (e.g. loose tape where tube secured or visible tube length appears longer/shorter		
	v. Concern about a patient who has been pulling at the tube/removed mittens.		
	If the tube is repositioned for any reason the tube position **must** be rechecked		
	f. Safe and Effective delivery of nutrition / medication / fluid		
	i. Ensure patient is in an upright position (30° to 45°) for feeding/ flushing/		
	administering medication		
	ii. Wash hands with liquid soap and dry before handling the feeding system		
	iii. External markings prior to **each** use **MUST** match initial tube length record		
	iv. Administer feed/flushes prescribed by Dietitian and record on fluid chart.		
	Administer prescribed medication (using a 30/50ml enteral syringe), flush the		
	tube with sterile water and record on the fluid/drug chart		
	vi. Ensure the tube is taped appropriately at all times		
	vii. Provide oral hygiene care for patient as clinically indicated		
	viii. Provide nasal care for patient as clinically indicated		

I confirm I have discussed this care plan with……signed……..designation……

Contact numbers:

- Nutrition Nurse Specialist (bleep 2667/ Ex: 3067)
- Nutrition Nurse (bleep 2673/ Ex: 3067)
- Nutrition and Dietetic Service (Ex :5552)
- Medicines information (Ex : 5021)

References:

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National Patient Safety Agency. Nasogastric tubes audit. Available online at: www.nrls.npsa.nhs.uk/resources/?entryid45=66675

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval

		Yes/No	Comments
1.	**Does the procedural document affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the procedural document likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the procedural document without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Director of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Human Resources.

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any procedural document when submitted to the relevant committee for consideration and approval.

	Title of document being reviewed:	Yes/No	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is it clear that the relevant people/groups have been involved in the development of the document?	Yes	
	Are people involved in the development?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
5.	**Evidence Base**		
	Are key references cited in full?	N/A	
	Are supporting documents referenced?	N/A	
6.	**Approval**		
	Does the document identify which committee/ group will approve it?	Yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with	Yes	

	Title of document being reviewed:	Yes/No	Comments
	and effectiveness of the document?		
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Executive Sponsor Approval			
If you approve the document, please sign and date it and forward to the author. Procedural documents will not be forwarded for ratification without Executive Sponsor Approval			
Name		Date	
Signature			
Relevant Committee Approval			
The Director of Nursing and Patient Experience's signature below confirms that this procedural document was ratified by the appropriate Governance Committee.			
Name		Date	
Signature			
Responsible Committee Approval – only applies to reviewed procedural documents with minor changes			
The Committee Chair's signature below confirms that this procedural document was ratified by the responsible Committee			
Name		Date	
Name of Committee		Name & role of Committee Chair	
Signature			

Tool to Develop Monitoring Arrangements for Policies and guidelines

What key element(s) need(s) monitoring as per local approved policy or guidance?	Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others if any.	What tool will be used to monitor/check/observe/Assess /inspect/ authenticate that everything is working according to this key element from the approved policy?	How often is the need to monitor each element? How often is the need complete a report ? How often is the need to share the report?	What committee will the completed report go to?
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**
Documentation which measures compliance with the correct procedures for insertion and confirming nasogastric (NG) tube placement	CNS Nutrition Dietitians to include this in their on going clinical reviews	Insertion sticker placed in the patient's notes every time a NG tube is inserted Evidence of pH range and external NG tube length recorded on the fluid chart/notes prior to the tube being used	Annual audit As per clinical reviews	Nutrition Steering Group Patient Safety Committee as required
Compliance with FY2 level and above having completed the eModule training tool for x-ray interpretation of NG tube position via the ESR e-learning portal within two weeks of joining the Whittington Hospital	Director of Medical Education (DME) in liaison with Learning and Development Heath Education North Central and East London (HENCEL) request information from DME re mandatory training uptake	ESR	Part of Mandatory Training monitoring	Patient Safety Committee