HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Nursing		
Document:	Internal Policy and Procedure		
Title:	Nasogastric Tube Feeding		
Applies To:	All Nursing Staff		
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1. PURPOSE:

1.1 To provide nursing staff with the guidelines in performing tube feeding.
1.2 To ensure that appropriate information is provided to patient/ significant others prior to the procedure to gain their cooperation and trust.

2. DEFINITONS:

2.1 **Tube feeding** (also known as enteral or gavage feeding) is the administration of nutrients directly into the stomach, duodenum, or jejunum through a tube.
2.2 **Gastrostomy tubes** are feeding tubes placed through the abdomen into the stomach. Gastrostomy tubes are used to give formula, liquids, and medicines.

3. POLICY:

3.1 This policy states that physician order must be verified before giving feed.
3.2 Nasogastric/ Gastrostomy tube must be in correct position and properly fixed before commencing gavage feeding.

4. PROCEDURE:

4.1 Identify the patient using 2 identifier (four names for Saudi or Complete name for Non-Saudi and Medical Record Number).
4.2 Explain the procedure to patient or to the significant others.
4.3 Provide privacy.
4.4 Assess bowel sound through the use of stethoscope.
4.5 Position patient with head of bed elevated at least 30 degrees.
4.6 Wash hands. Don gloves.
4.7 Assemble all needed equipment.
4.8 Check proper positioning of the nasogastric tube before commencing feeding.
4.9 Aspirate the stomach contents before feeding started and measure the amount prior to administration. Fill the bag with the nutritional feeding. Secure feeding port cap. Suspend the bag at least 20 inches above patients head. Squeeze site chamber 1/3 to ½ full. Remove cover from adapter. Open clamp and allow expelling air from tubing. Close clamp then connect feeding set adapter to tub. Adjust clamp to control flow rate.
4.10 Irrigate the catheter with sterile water when feeding is completed, clamp it off before the fluid reaches the end of the catheter, and keep in place for the next feeding.
4.11 Place the patient on right side at least one hour. Observe patient's condition after feeding; bradycardia and apnea may still occur.
4.12 Note for any vomiting or abdominal distension.
4.13 Observe patients activity.
4.14 Lower the bed one hour after feeding.

4.15 Document type and amount of feeding, amount of water given, and patient tolerance of the procedure. Evaluate and document health education provided including client.

5. MATERIALS AND EQUIPMENT:

5.1 Asepto syringe
5.2 Stethoscope
5.3 Nasogastric tube (different sizes)
5.4 Sterile gloves

6. RESPONSIBILITIES:

6.1 Nurse

7. APPENDICES:

7.1 N/A

8. REFERENCES:

8.1 Ministry of Health, General Nursing Administration, Functions and Duties Policies and Procedures

9. APPROVALS:

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