

## **Clinical Guideline: Gastric tube feeding Guideline for Staff on Neonatal units**

**Author: East of England Benchmarking group**

**For use in:** EoE Neonatal Units

Guidance specific to the care of neonatal patients.

**Used by:**

**Key Words:**

**Date of Ratification: September 2021**

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**Approved by:**

<b>Neonatal Clinical Oversight Group</b>	
Clinical Lead Matthew James	<b>Matthew James</b>

**Ratified by ODN Board:**

<b>Date of meeting</b>	<b>September 2021</b>
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**Audit Standards:**

**100% of babies will have documented evidence of placement of tube. 100% of babies will have a record of the length and pH at time of insertion**

**100% of babies will have documented evidence of assessment of tube position**

**Audit points**

Audit will be through annual benchmarking activity and consequent action planning using infant's records to assess quality outcomes and guideline adherence. Poor scores may necessitate more frequent audits to ensure progress is being made.

**Purpose:**

To provide guidance on insertion, testing and feeding of infants on neonatal units and ensure patient safety for all infants fed with gastric tubes, either via the Naso-gastric or Orogastric insertion method.

**Target Population:**

Nurses, nursery nurse, health care assistants and medical staff; students, under direct supervision of a competent person, undertaking practice placements caring for infants on Neonatal units.

**Background:**

Historically incidents have been recorded relating to the use of misplaced Nasogastric tubes<sup>1</sup> and inappropriate use of medical equipment<sup>2</sup>. Even after alerts were sent out to highlight these issues, incidents still occurred in significant numbers to necessitate a further alert,<sup>6,7</sup> to highlight the dangers surrounding the use of Enteral tubes.

Recommendations were also given relating to training of staff and the safe use of gastric tubes<sup>7</sup>. Implementing a guideline to be used throughout the network ensures care practices are standardised and monitored for compliance to best practice throughout the region.

**Introduction:**

Within the neonatal environment passing & using gastric tubes is an integral part of care and daily routine for many of the babies. It provides a vital method of delivering nutrients to the infant, with minimal energy expenditure, thus supporting growth and development. It is a blind procedure, meaning that we cannot visually confirm the exact placement of the tube when in use. Therefore the need to follow a clinical procedure to confirm the position of the tube on insertion or prior to use is essential to minimise the risk of using a misplaced gastric tube. Documentation of competency to perform this vital skill for staff is necessary for units to be able to evidence adherence to quality and safety through auditing/ benchmarking processes.

### **Objectives:**

- To provide guidance on insertion of gastric tubes
- To provide guidance on how to test gastric tubes for correct tube position
- To provide guidance on the administration of gastric feeds and medicines
- To provide guidance on how to vent air from the stomach for patients who
  - I. Have had bag and mask ventilation
  - II. Are on nasal CPAP
  - III. Have abdominal distension

### **CONTRAINDICATIONS:**

There is an increased risk of causing trauma or misplacing a Gastric Tube in patients who have the following contraindications. The competent practitioner passing the tube should determine the safest method of placement. If there is any doubt, this should be highlighted to the nurse in charge or medical team for clarification.

- Anatomical deformity
- Trauma
- Recent oral, nasal or oesophageal surgery (caution should be used if enteral tube is dislodged)

### **Exclusion of congenital anomalies:** <sup>10</sup>

The inability to pass a nasogastric tube beyond the nares is indicative of Choanal atresia and is a medical emergency.

Resistance to passage of a gastric tube beyond the oropharynx is indicative of oesophageal atresia.

A gastric tube should be inserted prior to chest or abdominal x-ray to facilitate differential diagnosis.

### **Equipment:**

Radio Opaque NG Tube with externally visible length markings

An enteral safe<sup>2, 12</sup> Syringe 5mls<sup>13</sup> for aspiration depending on the size of the Infant.

PH Indicator strips CE marked reflecting 0.5 increments

Hydrocolloid skin protection and adhesive to secure the Tube

Gloves

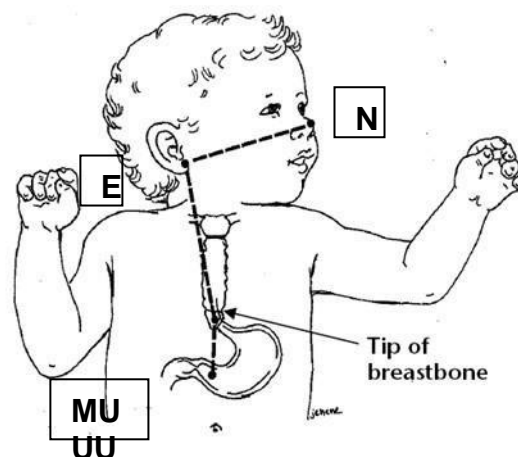
Oxygen, bag and mask and Suction should be checked, working and accessible throughout the procedure

### **Determining length of the tube:**

A fine bore gastric tube ranging from size 4 to 6 can be used depending on the size of the Neonate and density of the feed.<sup>9</sup> A Larger bore gastric tube should be used for babies requiring gastric drainage.

The following technique should be used to determine the length of gastric tube placement<sup>5</sup>.

Measure the length of the gastric tube using NEMU (Nose, Ear, and Mid-Umbilicus)



**If passing a naso-gastric tube:** Measure from the tip of the infants' nose to the earlobe and from the earlobe to the point midway between the xiphoid process (tip of breast bone) and umbilicus

**If passing an oro-gastric tube:** Measure from the midline of the infants' mouth to the earlobe and from the earlobe to the point midway between the xiphoid process (tip of breast bone) and umbilicus

Make a note of the length to be inserted.

1. In the first action and rationale, include that the rationale for explaining procedure to parent and giving information, is not only about alleviating stress and co-operation, it is about involving them in the care decisions of their babies.
2. We think there should be an action that states, "Wherever possible, encourage parents to be present during the procedure" and then the rationale would be 2-fold - firstly, as above it is to ensure families are involved in as much of their baby's care as possible; and secondly, as per pain management evidence, parental presence (comfort holding/speaking to baby etc) can minimise pain for the baby.  
We realise that gastric tube insertion isn't necessarily "painful" but it is certainly uncomfortable and so we would suggest that parent comfort during the procedure is beneficial.
3. It would be good to have a section about how to involve and educate families so that they can deliver tube feeds for their babies.

The goal of FICare is to facilitate a partnership and collaboration between parents and the NICU staff, to promote parent-infant interactions, and to build parent confidence. This is achieved by promoting information sharing between staff and parents and by parent participation in their infants care. Under the FICare model, parents are taught to be involved in all possible aspects of their infant's care

Action	Rationale
<p>If possible, explain procedure to parents/carers and offer information leaflet prior to procedure. Update parents as soon as reasonably possible</p>	<p>To ensure that parents are involved as partners in care for their babies through promoting information sharing between staff and parents and by parent participation in all aspects of their infants' care.</p>
<p>Document rationale for passing gastric tube in healthcare records.</p> <p>Date, time and sign including designation.</p> <p>If a patient requires an x-ray, ensure the enteral tube is passed prior to the x-ray being taken</p>	<p>To ensure the needs of the patient requiring an enteral tube are greater than the risks of incorrect placement. Provides at a glance evidence of placement and length of tube.</p> <p>To avoid unnecessary x-ray exposure.</p>
<p>Ensure the Infant, has not been fed for a minimum of 15-30 minutes prior to passing the gastric tube</p>	<p>To avoid the risk of vomiting and aspiration during procedure</p>
<p>Prepare the appropriate equipment and ensure oxygen and suction is checked and readily available</p>	<p>To avoid unnecessary interruptions to procedure and to ensure the environment is safe to proceed</p>
<p>Wash and dry hands, non-sterile gloves should be worn if required by local trust</p>	<p>To prevent cross infection as per local Infection Control Policies</p>
<p>Consider the baby's comfort during the procedure and select an appropriate care strategy to minimise discomfort. i.e. swaddling, sucrose, non-nutritive sucking.</p>	<p>To minimise stress and discomfort during the procedure.</p>
<p>Wherever possible, encourage parents to be present during the procedure.</p>	<p>To facilitate the involvement of families in the care of their babies as much as possible; [16]</p> <p>As per pain management evidence, parental presence (comfort holding/speaking to baby etc) can minimise pain for the baby. We realise that gastric tube insertion isn't necessarily "painful" but it is certainly uncomfortable and so we would suggest that parent comfort during the procedure is beneficial. [20]</p> <p>Parents find pain and discomfort the most distressing aspect of the NICU and also wish to actively participate in comforting their infant. These approaches are consistent with modern family-centred care</p>

	in neonatal units in which the best interests of the infant and family are put ahead of staff convenience.
Position baby in the supine position with head in neutral position.	Hyper extension of the neck can occlude the airway.
Check the tube is intact. The tube should be stretched to remove any shape retained from being packaged	Establish patency of tube
Select nostril that is clear, if replacing tube use alternative nostril from which the tube was originally placed-if appropriate.	To prevent long term irritation and skin damage
Determine the length of the tube to be inserted. <b>For Naso-gastric tube placement:</b> (see above picture) Select a clear nostril, insert the tip of the tube into the nostril and slide backwards and downwards along the floor of the nose. Advance	To estimate accurate placement in the stomach following normal anatomical structures.

the tube steadily* to the predetermined length. <b>For Oro-gastric tube placement:</b> Insert the tip of the tube into the mouth and slide it backwards and inwards along the tongue to the oropharynx and advance steadily* to the predetermined length. *Insertion of tube should take around 15 seconds to minimise stimulation of vagal nerve. <small>14 With OGT there is an increased possibility of apnoea and bradycardia due to vagal stimulation.</small>	
If at any time the baby shows signs of bradycardia, apnoea, vomiting or respiratory difficulties such as tachypnoea or harder or becomes cyanotic: stop the procedure immediately and remove the tube.	To prevent the deterioration of the infant.
If there is any resistance/ obstruction on insertion, pull back, turn the tube slightly and advance again. If obstruction occurs again try the other nostril. If resistance is still felt, stop the procedure and seek senior help. Do not force the tube.	To avoid causing perforation of the oropharynx, pneumothorax or damage to delicate mucosa <sup>1</sup>  Consider Choanal Atresia, Tracheal Oesophageal Fistula / atresia if a tube has not been previously successfully passed. <sup>10</sup>

<p>To assess tube position, aspirate 0.2 to 1ml stomach contents using a 2.5ml to 5ml syringe.<sup>13</sup></p> <p>Check contents are gastric by using pH strips. The pH should be less than 5.5<sup>3</sup> If pH range falls between 5 and 6, the tube position should be assessed with a second competent person.</p>	<p>To ensure accurate placement of the tube prior to feeding</p> <p>The NPSA has highlighted the potential difficulty experienced by some staff in differentiating pH readings using currently available pH indicator strips between pH range of 5 and 6. Even though aspirates testing pH 5.5 and below should indicate correct placement in most babies. Best practice would be to confirm with a second person that the pH is 5.5.</p>
<p>If pH is <math>\geq 6</math>, it is not deemed safe to feed, without undertaking a full risk assessment with another competent nurse following the guidance in Appendix 2</p>	<p>A pH 6 and above. There are many factors in neonates that affect the results from pH indicator strips or paper including:</p> <ul style="list-style-type: none"> <li>• gestation;</li> <li>• postnatal age;</li> <li>• small volumes of aspirate;</li> <li>• medications that affect the gastric pH;</li> <li>• Continuous and frequent feeding.</li> </ul> <p>Staff should consider the factors for each patient that may contribute to a high gastric pH (pH 6 or above) when risk assessing. Any decision made must ensure the safety of the patient using the best information available</p>

<p>patient's name, hospital number and date of insertion</p>	<p>practice, therefore labelling of the gastric tube will be determined by local policy.</p>
<p>Document gastric tube size and length on the appropriate documentation kept in either the health care records or the bedside nursing notes each time a new tube is passed.</p>	<p>To minimise risk, in accordance with the Professional Standards for nurses and midwives.<sup>4</sup> A reference measurement will provide a benchmark for the risk assessment of tube position and movement.</p>

<p>If the length of tube is advanced, retracted or repositioned, alterations should be clearly documented in the healthcare / nursing records.</p>	<p>To ensure patient safety with correctly documented changes.</p>
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<p>When securing an oro-gastric tube, Care should be taken not to damage the lips or gums or obstruct the use of the tongue.</p>	<p>This can occur if the tube is pulled too tightly when securing the tube.</p>
<p>Every time a gastric tube is inserted, or on subsequent reinsertions, complete the local trust gastric placement checklist record.</p>	<p>To keep a documented record of all tube insertions and subsequent reinsertions. <sup>1</sup></p>
<p>Manufacturing guidelines should be followed to determine routine tube changes.</p>	<p>To avoid irritation to the baby's mucosal lining within the stomach</p>
<p>If a child requires a gastric tube for abdominal distension due to paralytic ileus, gastrointestinal disease or following gut surgery, leave the tube on free drainage. Aspirate the tube as indicated and requested and check tube position. Large bore gastric tubes should be used for babies requiring gastric drainage.</p>	<p>To allow drainage of gastric contents and facilitate early gastric motility. To avoid aspiration of gastric contents.</p>
<p>If a child is on nasal Continuous Positive Airway Pressure (nCPAP) or has received bag valve mask ventilation, the gastric tube can be left on free drainage if NBM. The open end of the tube should be raised above the level of the stomach. If not on free drainage, Aspirate stomach contents 4-6hrly and check tube position. In units that practice continuous venting following administration of feeds: This can be facilitated by securing the end of the tube above the head of the infant, with an enteral syringe attached to create a reservoir should gastric contents reflux. <sup>11</sup></p> <p>Documentation should be kept up to date including the aspirate</p>	<p>To prevent accumulation of air in the stomach. To avoid aspiration of gastric contents.</p>
<p>Factors that may affect the gastric pH <sup>1</sup> Gestation; postnatal age (presence of amniotic fluid); small volumes of aspirate; medications (anti reflux/antacids); continuous and frequent feeding; use of fine bore tubes. Staff should consider the risk factors for each</p>	<p>All can cause either an elevated pH (<math>\geq 6</math>) or an insufficient aspirate volume to test.</p>
<p>patient that may contribute to a high gastric pH (<math>\geq 6</math>).</p>	
<p><b>The following methods should NOT be used to confirm feeding tube placement <sup>1</sup></b></p>	



<p><b>Absence of respiratory distress</b></p>	<p>Small bore tubes can enter the respiratory tract with few, if any, symptoms, and large bore tubes can enter a patient's respiratory tract without any symptoms being shown, particularly if the patient is unconscious.</p>
<p><b>Appearance of feeding tube aspirate</b></p>	<p>Research and anecdotal evidence indicate that relying on the appearance of feeding tube aspirate is unreliable as a primary testing method as gastric contents can look similar to respiratory secretions</p>
<p><b>Radiography - should NOT be used routinely but should be used if the baby is being xrayed for another reason. However, if all other attempts to confirm tube position fail, then X-ray should be undertaken. Tubes with markings should be used for all babies to enable accurate measurement of depth and length and the position of the tube documented. All tubes used should be radioopaque.</b></p>	<p>Routine radiography for feeding tube placement would result in excessive and unnecessary exposure to radiation, loss of feeding time, increased handling of the baby, and would not be cost effective.</p>
<p>Observe the infant until the feed is complete.</p>	<p>To be present to take prompt action to ensure no adverse event occurs during the feed or minimise the effects of a tube becoming dislodged by responding promptly.</p>
<p>Involve and educate the family in safely checking pH aspirates and tube feeding their babies on the unit.</p>	<p>To ensure that parents are involved as partners in care for their babies through promoting information sharing between staff and parents and by parent participation in all aspects of their infants' care.[16] The improved confidence and skills of parents involved in their baby's care increases parental readiness as they transition from hospital to home, improves management abilities at home, and lowers parental anxiety. Additionally, family/parental involvement enables staff to feel more confident in the parents' abilities which then facilitates earlier discharge. [16]</p>

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### Securing and skin care

- Once the gastric tube is deemed as safe to use, secure the tube with the appropriate tape. Maintaining the skin integrity is essential as damage to the skin can occur. The more preterm the baby the more damage that can be inflicted on the superficial cell layer as it is torn away when the tape is later removed.
- Use Hydrocolloid dressing (extra thin) on the skin; then secure the feeding tube to the Hydrocolloid dressing with adhesive tape. Adhesive tape should not be shared amongst patients to comply with local infection control guidance. Reassess the baby's condition and make the baby comfortable.

### When to check the tube position

- Following initial insertion;
- Before administering each feed;
- Before giving oral medication;
- Following vomiting, retching or coughing;

- If there is evidence of displacement. For example, if the tape is loose or the tube appears longer or kinked;
- If the baby is on continuous feeds, tube checking should be synchronised with syringe changes. When continuous feeding has stopped, wait 15 – 30 minutes to allow the stomach to empty and the pH level to fall.

### **On-going management and documentation**

- Check on the relevant paperwork, the date that the tube was inserted and the length that the tube is inserted to.
- Check position of the gastric tube at the nostril or the lips, every time the tube is used and record on the feeding chart or electronic record
- When aspirating the feeding tube and testing the pH, ensure that the value of the pH, and the colour, consistency and volume of aspirate, is recorded on the feeding chart or electronic record.
- If the baby requires a chest x-ray, where possible ensure that the tube is passed prior to the x-ray being carried out. The most accurate method for confirming correct tube placement is radiography. However x-ray for the sole purpose of confirming gastric tube position is not recommended.
- Change gastric tube according to manufacturer's recommendations <sup>9</sup>
- If using a non-adhesive remover to remove tape, ensure manufacturer's instructions are followed and product is suitable to be used on the face.
- When the tape is removed, clean area with water and dry thoroughly.
- When replacing gastric tubes, where possible alternate nostrils should be used.

### **Complications**

- Vagal stimulation – bradycardias and apnoeas <sup>8</sup>
- Increased work of breathing
- Aspiration, perforation of the oesophagus, posterior pharynx, stomach, duodenum;
- Small bowel perforation;
- Necrotising enterocolitis

### **Monitoring and Audit**

Audited annually, in line with the East of England Benchmarking standards

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**APPENDIX ONE (A)**

**The recommended procedure for checking the position of the naso and orogastric feeding tube in babies under the care of neonatal units Use this flow chart as a basis for decision making:**

Action	Rationale
Check for signs of tube displacement (if not initial insertion)	The tube may have coiled up in the mouth or if there is more tube visible than previously documented, the tube may have kinked. Loose tape may indicate movement. If tube has been displaced, it will need repositioning or re-passing before feeding.
Aspirate 0.2-1ml gastric fluid and allow ten to fifteen seconds for any colour change	0.2 to 1ml of aspirate will cover an adequate on single, double or triple reagent panels of pH testing strips or paper.
Aspirate using an enteral syringe	It is safe practice to use gastric tubes and enteral syringes that have non luer lock connectors (Building a Safer NHS for Patients: Improving Medication Safety published 22/01/2004 available at <a href="http://www.dh.gov.uk">www.dh.gov.uk</a> )
Aspirate is pH 5.5 or below PROCEED TO FEED	Aspirates testing pH 5.5 and below should indicate correct placement in most babies (including the majority of those receiving acid suppressants) and rule out the possibility of respiratory tract placement. Always match the pH indicator strip or paper colour change with the colour code chart on the booklet or box. If there is ANY doubt about the position and/or clarity of the colour change on the pH indicator strip or paper, particularly between pH5 or 6, DO NOT commence feeding.

Aspirate is pH6 or above  
CAUTION – STOP FEED:  
If clinically safe, consider waiting 15-30 minutes before aspirating again. Consider replacing and/or re-passing the tube and re-aspirating

If still pH 6 or above, seek advice

IT IS IMPORTANT THAT STAFF FOLLOW THE FLOWCHART, RECORD THE OUTCOMES AND MAKE DECISIONS BASED ON THIS INFORMATION

Document all information

Problems obtaining aspirate: suggest using larger size tubes with multiple ports. Turn baby onto his/her side

Inject 1-2ml of air using a syringe

Advance or retract the tube 1-2cm  
Stop if there is any resistance or obstruction

The most likely reason for failure to obtain gastric aspirate pH 5.5 or below is the dilution of gastric acid by enteral feed. Waiting gives time for the stomach to empty and the pH value to fall. If pH is still 6 and above after waiting and replacing or re-passing the tube, seek advice and consider the following questions:

- Is the baby on medication?
- Is the baby only 24 to 48 hours old?
- Is the tube in the same position as previously documented on an x-ray?
- Is the visible length of the tube the same as previously documented?
- What is the trend in pH values?
- What is the volume of aspirate?

It is important that actions and their rationale are documented. Clinical staff should balance the risks of not feeding a baby in the short term with feeding when there is the possibility of the tube being in the lungs. Only consider x-ray if timely e.g. if the baby is due for an x-ray for other reasons, and/or it is clinically safe to do so. If an x-ray is done, the radiographer should know this advice has been followed and the reason for the request should be documented.

Documenting helps the clinical decision-making process. The tube size and length should be recorded each time the tube is passed. A record should also be made each time measurements of the pH level of the aspirate and the length of the tube's advancement or retraction are done.

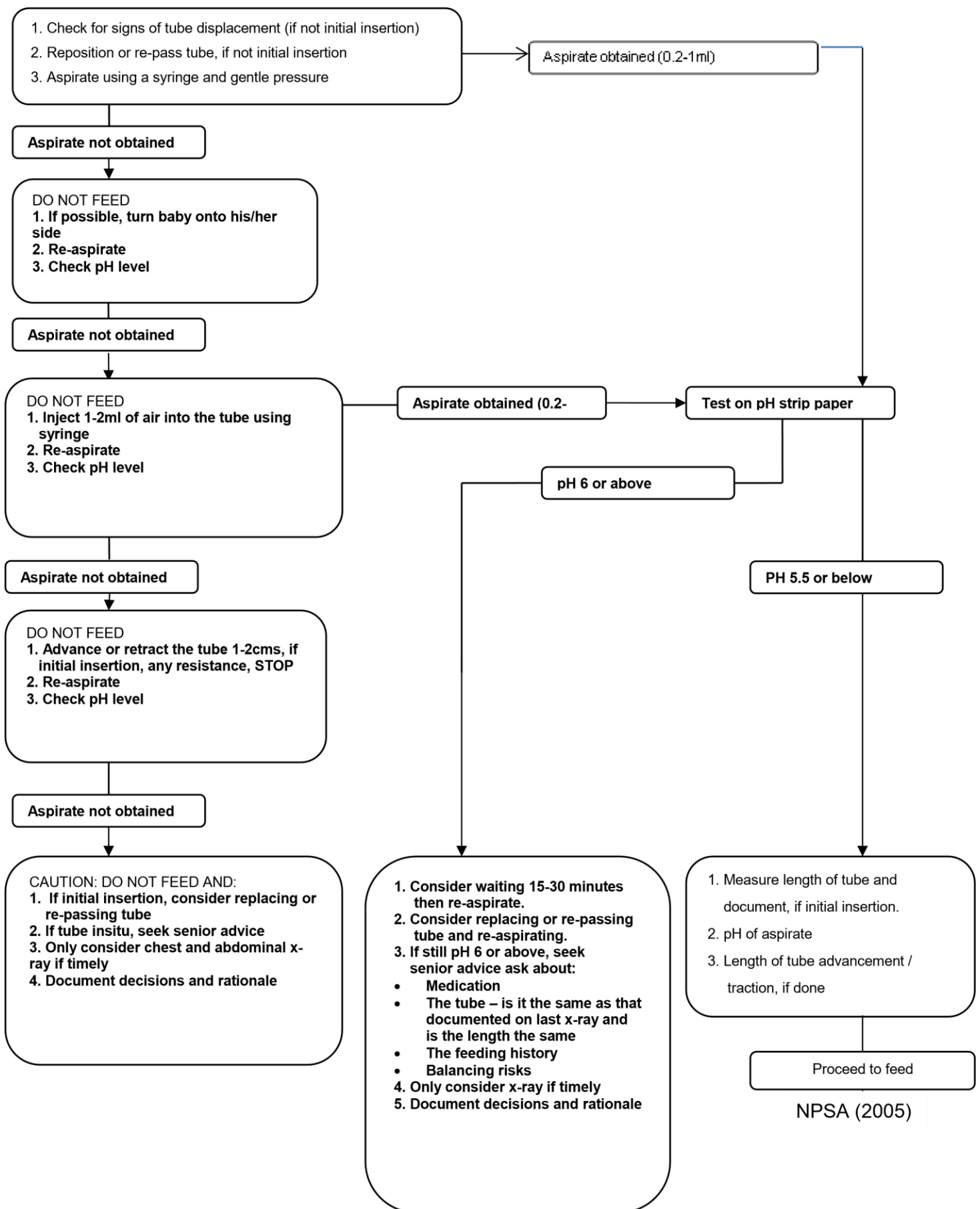
This may facilitate the tip of the nasogastric tube entering the gastric fluid pool.

Injecting air through the tube may dislodge the exit port of the feeding tube from the gastric mucosa. Care must be taken when using large syringes on neonates to ensure that the correct amount of air is inserted, i.e. no more than 2ml.

If the tube is in the oesophagus, advancing it may allow it to pass into the stomach. If the tube has been inserted too far, it may be in the duodenum. Consider withdrawing a few centimetres and re-aspirating. The position of the tube at the nose should already have been recorded and marked, if the tube is in situ. If the mark has not moved then

advancing or retracting may not make a difference. Document the length of tube if moved.

If you still cannot obtain aspirate If this is an initial insertion then consider replacing or re-passing the tube. If the tube has been in situ already, seek advice. Consider whether the length of the tube has changed and discuss options as outlined under the action point on aspirate of pH 6 and above. Record all decision and their rationale.





## Exceptional Circumstances Form

Form to be completed in the **exceptional** circumstances that the Trust is not able to follow ODN approved guidelines.

Details of person completing the form:	
Title:	Organisation:
First name:	Email contact address:
Surname:	Telephone contact number:
Title of document to be excepted from:	
Rationale why Trust is unable to adhere to the document:	
Signature of speciality Clinical Lead:	Signature of Trust Nursing / Medical Director:
Date:	Date:
Hard Copy Received by ODN (date and sign):	Date acknowledgement receipt sent out:

Please email form to: [mandybaker6@nhs.net](mailto:mandybaker6@nhs.net) requesting receipt.

Send hard signed copy to: Mandy Baker

EOE ODN Executive Administrator

## APPENDIX 1 – VERSION CONTROL SUMMARY

**Document Title: Gastric tube feeding Guideline for Staff on Neonatal units**

Version Number	Purpose / Changes	Author	Date Changed
1	New document	East of England neonatal Benchmarking group	26TH March 2018
2	Updated document	East of England Benchmarking Group	August 2021

