

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

Review due: September 2024

Registration No: NEO-ODN-2021-5

Approved by:

Neonatal Clinical Oversight Group	
Clinical Lead Matthew James	Matthew James

Ratified by ODN Board:

	September 2021
Date of meeting	



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 tubes¹ and inappropriate use of medical equipment². Even after alerts were sent out to highlight these issues, incidents still occurred in significant numbers to necessitate a further alert,^{6,7} 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 tubes⁷. 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: ¹⁰

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^{2, 12} Syringe 5mls¹³ 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.⁹ 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 placement⁵.



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 gastic 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
If possible, explain procedure to parents/carers and offer information leaflet prior to procedure. Update parents as soon as reasonably possible	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.
Document rationale for passing gastric tube in healthcare records. Date, time and sign including designation. If a patient requires an x-ray, ensure the enteral tube is passed prior to the x-ray being taken	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. To avoid unnecessary x-ray exposure.
Ensure the Infant, has not been fed for a minimum of 15-30 minutes prior to passing the gastric tube	To avoid the risk of vomiting and aspiration during procedure
Prepare the appropriate equipment and ensure oxygen and suction is checked and readily available	To avoid unnecessary interruptions to procedure and to ensure the environment is safe to proceed
Wash and dry hands, non-sterile gloves should be worn if required by local trust	To prevent cross infection as per local Infection Control Policies
Consider the baby's comfort during the procedure and select an appropriate care strategy to minimise discomfort. i.e. swaddling, sucrose, non-nutritive sucking.	To minimise stress and discomfort during the procedure.
Wherever possible, encourage parents to be	To facilitate the involvement of families in
present during the procedure.	the care of their babies as much as possible; [16] 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] 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



	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	Hyper extension of the neck can occlude
neutral position.	the airway.
Check the tube is intact.	Establish patency of tube
The tube should be stretched to remove any	
shape retained from being packaged	
Select nostril that is clear, if replacing tube use	To prevent long term irritation and skin
alternative nostril from which the tube was	damage
originally placed-if appropriate.	
Determine the length of the tube to be inserted.	To estimate accurate placement in the
For Naso-gastric tube placement: (see above	stomach following normal anatomical
picture)	structures.
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	
the tube steadily* to the predetermined length.	
For Oro-gastric tube placement:	
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.	
due to vagal stimulation.	
If at any time the baby shows signs of	To prevent the deterioration of the infant.
bradycardia, apnoea, vomiting or respiratory	
difficulties such as tachypnoea or harder or	
becomes cyanotic: stop the procedure	
immediately and remove the tube.	
If there is any resistance/ obstruction on	To avoid causing perforation of the
insertion, pull back, turn the tube slightly and	oropharynx, pneumothorax or damage to
advance again. If obstruction occurs again trv	delicate mucosa'
the other nostril. If resistance is still felt, stop the	Consider Choanal Atresia. Tracheal
procedure and seek senior help. Do not force the	Oesophageal Fistula / atresia if a tube
tube.	has not been previously successfully
	passed ¹⁰
	paccoa.



To assess tube position, aspirate 0.2 to 1ml stomach contents using a 2.5ml to 5ml syringe. ¹³	To ensure accurate placement of the tube prior to feeding
Check contents are gastric by using pH strips. The pH should be less than 5.5 ³ If pH range falls between 5 and 6, the tube position should be assessed with a second competent person.	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.
If pH is ≥6, it is not deemed safe to feed, without undertaking a full risk assessment with another competent nurse following the guidance in Appendix 2	 A pH 6 and above. There are many factors in neonates that affect the results from pH indicator strips or paper including: gestation; postnatal age; small volumes of aspirate; medications that affect the gastric pH; Continuous and frequent feeding. 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

patient's name, hospital number and date of	practice, therefore labelling of the gastric
insertion	tube will be determined by local policy.
Document gastric tube size and length on the	To minimise risk, in accordance with the
appropriate documentation kept in either the	Professional Standards for nurses and
health care records or the bedside nursing notes	midwives. ⁴ A reference measurement will
each time a new tube is passed.	provide a benchmark for the risk
	assessment of tube position and
	movement.
If the low oth of tube is advisuant, retracted or	To ensure notions option to a fath with a smarth r

If the length of tube is advanced, retracted or	To ensure patient safety with correctly
repositioned, alterations should be clearly	documented changes.
documented in the healthcare / nursing records.	



When securing an oro-gastric tube, Care should be taken not to damage the lips or gums or obstruct the use of the tongue	This can occur if the tube is pulled too tightly when securing the tube.
Every time a gastric tube is inserted, or on subsequent reinsertions, complete the local trust gastric placement checklist record.	To keep a documented record of all tube insertions and subsequent reinsertions. ¹
Manufacturing guidelines should be followed to determine routine tube changes.	To avoid irritation to the baby's mucosal lining within the stomach
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.	To allow drainage of gastric contents and facilitate early gastric motility. To avoid aspiration of gastric contents.
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.	To prevent accumulation of air in the stomach. To avoid aspiration of gastric contents.
Documentation should be kept up to date including the aspirate	
Factors that may affect the gastric pH ¹ 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 patient that may contribute to a high gastric pH	All can cause either an elevated pH (≥6) or an insufficient aspirate volume to test.
(<i>2</i> 0).	
The following methods should NOT be used to confirm feeding tube placement ¹	



Absence of respiratory distress	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.
Appearance of feeding tube aspirate	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
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.	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.
Observe the infant until the feed is complete.	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.
Involve and educate the family in safely checking pH aspirates and tube feeding their babies on the unit.	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]



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 ⁹
- 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 ⁸
- 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

References

- 1. NPSA (2005) *Patient Safety Alert:* Reducing the harm caused by misplaced naso and orogastric feeding tubes in babies under the care of neonatal units. August:09
- 2. Stayconnected (2016) ISO 80369-1:2010, Small-bore connectors for liquids and gases in healthcare applications — Part 1: General requirements
- 3. Freer. Y. (2005) Nasogastric Tube Aspirate pH values associated with typical enteral feeding patterns in infants admitted to a NICU. Journal of Neonatal Nurses. 11.pg.106109
- 4. NMC (2015) The Code: Professional standards of practice and behavior for nurses and Midwives. March
- Ellet M et al (2011) Comparing Methods of Determining Insertion Length for Placing Gastric Tubes in Children 1 Month to 17 Years of Age Found At: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3290655/ Accessed: April 2017
- 6. NPSA (2016) Patient safety alert. Nasogastric tube misplacement: continuing risk of death and severe harm. 22 July
- NPSA (2011) Patient Safety Alert NPSA/2011/PSA002: Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants. March
- 8. Boxwell. G. (2020) Neonatal Intensive care Nursing. Gastric Tube Placement. Chapter 13.Diagnostic and Therapeutic procedures.
- Medicina (online) Medicina nasgastric feeding tubes found at: http://www.eurosterielmedical.nl/sites/default/files/handleidingen/medicina/ nasogastric_booklet_rev1.pdf Accessed May 2017
- 10. Royal Cornwall NHS Trust (2013) Clinical guideline for the care of a neonate, child or Young person requiring NG/NO tube. 22nd July. Found at: http://www.rcht.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Cli nical/Neonatal /NasoOrogastricTubeGuidelineForTheCareOfNeonateChildOrYoungPerso nRequiring.pd f Accessed: June 2017
- 11. The Royal Children's Hospital Melborne. (2015) Enteral feeding and medication administration. Clinical guidelines. December. Found at: http://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Enteral_fe eding_and_me dication_administration/ Accessed: June 2017

- 12. Holland, M. (2015) Enhancing Patient Safety in Enteral Feeding. Nursing Times. 111 (38) pp22-23.
- 13. Knox, t; Davie, J. (2009) Nasogastric tube feeding- which syringe size produces lower pressure and is safest to use? *Nursing times.* 105 (27) pp24-26
- 14. Bohnhorst, B; Cech, K; Peter, C; Doerdelmann, M.(2010) Oral versus nasal hypoxemia and bradycardia in infants with apnoea and prematurity. *Neonatology*. 98 (2) 143-149.
- 15. Marsha L, et al (2011) Predicting insertion length for gastric tube placement in Neonates. *Journal of Obstetric gynaecological Neonatal Nursing* Jul: 40(4) pg. 412421

16. **Family Integrated Care (2020)** <u>About FICare - Family Integrated</u> <u>Care [http://familyintegratedcare.com/about-</u> ficare/#:~:text=The%20Family%20Integrated%20Care%20%28FICare%2 9%20model%20is%20an,had%20previously%20been%20in%20the%20NI CU%20%28veteran%20parents%] Accessed: 20 September 2021

17. Parents' Use of Nonpharmacologic Methods to Manage Procedural Pain in Infants Tarja Pölkki, Anne Korhonen, and Helena Laukkala JOGNN, 47, 43–51; 2018. <u>https://doi.org/10.1016/j.jogn.2017.10.005</u> Accessed: 20 September 2021

Bibliography

- 1. Norfolk and Norwich University Hospitals (2016) Trust Guideline for the Safe Management of Parents and Carers Undertaking Nasogastric tube feeding to their own Baby. Version 3
- Basildon and Thurrock NHS foundation Trust (2016) Naso / Orogastric tubes – Passing and Management in infants, children and young people. Version 2
- 3. Amos. N and Brown. D. (2017) Department guideline for: Management of Enteral Tubes. East and North Herts NHS Trust. Version 2. January
- 4. The Ipswich Hospital (2016) Neonatal Gastric tubes: Insertion, testing and feeding. Version 3

All Rights Reserved. The East of England Neonatal ODN withholds all rights to the maximum extent allowable under law. Any unauthorised

Gastric tube feeding Guideline for Staff	Page 12 of
on Neonatal units	Fage 15 01 5

broadcasting, public performance, copying or re-recording will constitute infringement of copyright. Any reproduction must be authorised and consulted with by the holding organisation (East of England Neonatal ODN).

The organisation is open to share the document for supporting or reference purposes but appropriate authorisation and discussion must take place to ensure any clinical risk is mitigated. The document must not incur alteration that may pose patients at potential risk. The East of England Neonatal ODN accepts no legal responsibility against any unlawful reproduction. The document only applies to the East of England region with due process followed in agreeing the content.

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 www.dh.gov.uk)
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.

Gastric tube feeding Guideline for Staff	Page 14 of 5
on Neonatal units	

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	 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?
If still pH 6 or above, seek advice	 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
IT IS IMPORTANT THAT STAFF FOLLOW THE FLOWCHART, RECORD THE OUTCOMES AND MAKE DECISIONS BASED ON THIS INFORMATION	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.
Document all information	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.
Problems obtaining aspirate: suggest using larger size tubes with multiple ports. Turn baby onto his/her side	This may facilitate the tip of the nasogastric tube entering the gastric fluid pool.
Inject 1-2ml of air using a syringe	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.
Advance or retract the tube 1-2cm Stop if there is any resistance or obstruction	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.

Gastric tube feeding Guideline for Staff	Page 15 of 5
on Neonatal units	Fage 15 01 5



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	d from:
Rationale why Trust is unable to	adhere to the document:
Signature of speciality Clinical L	ead: Signature of Trust Nursing / Medical Director:
Date:	Date:
Hard Copy Received by ODN (d and sign):	ate Date acknowledgement receipt sent out:
Plaze omail form to: mandyhal	cor6@phs pot requesting receipt

Please email form to: mandybaker6@nhs.net requesting receipt.

Send hard signed copy to: Mandy Baker EOE ODN Executive Administrator

Gastric tube feeding Guideline for Staff	Dogo 17 of
on Neonatal units	Fage 17 015

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

Gastric tube feeding Guideline for Staff	Page 18 of
on Neonatal units	

Gastric tube feeding Guideline for Staff	Page 10 of
on Neonatal units	Fage 19 01 5