**POLICY**

Place a gastric tube orally or nasally for the purpose of gastric decompression, drainage or enteral feeding. Research has shown that gastric tubes can migrate internally while externally the tube looks secure. Check for correct positioning of the gastric tube at each of the following times:

- following initial placement
- every 4 hours with bolus feeds; or once per shift with a continuous feed
- before giving medication
- minimally once a shift when NPO
- whenever there is a risk or evidence of displacement e.g. following vomiting, retching, with traction etc.

**Applicability:** Nasogastric (NG) / Orogastric (OG) insertion, removal and care within the Neonatal Program.

No single method to check NG/OG placement is reliable. The following methods will help determine the correct position.

- Check tape is secure.
- Ensure measurement is correct at nostril or lip referring to Bedside Information Tool (BIT) for documented insertion depth.
- Assess for signs of displacement
  - Increased labile saturations, bradycardias, or apneas
  - Vomiting, coughing, excessive crying
- Check aspirate for colour and pH trend

The indwelling gastric tube is to be labeled with the date it was last changed.

- **A gastric tube** is changed routinely q72 hours. Surgically placed gastric tubes require surgical consultation before removal/changing.
- **A silicone (silastic) feeding tube** is changed q30 days and may be rinsed and re-inserted for the same patient if removed prior to this time

*(A gastric tube is pinched off during removal to avoid dripping fluid into the pharynx)*

**PROCEDURE**

**Gather Equipment:**
1. 5, 6 or 8 Fr gastric feeding tube or replogle tube
2. 3 - 5mL enteral (orange) feeding syringe for aspirating (a small syringe produces less pressure)
3. Opsite, comfeel and red tape
4. Sterile disposable glove
5. pH testing strip
6. Sterile water (for lubrication)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Note</th>
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| 1. Measure to determine depth of insertion. | - Measure from the bridge of Nose to the Earlobe to between Xiphoid and Umbilicus (NEXU).  
- Example of minimal length for OG tubes. |
### GASTRIC TUBE PLACEMENT PROCEDURE

<table>
<thead>
<tr>
<th><strong>Check NG / OG for Correct Placement</strong></th>
<th><strong>Note</strong></th>
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| 5. Gently aspirate 0.5 mL of gastric fluid. | To avoid vagal response and bradycardia.  
- Stop continuous feed for 15-30 minutes and aspirate.  
- With replogle tube, air vent must be open to aspirate. |
| 6. If unable to obtain an aspirate, attempt the following and aspirate again: | Getting aspirate from a fine bore feeding tube may be difficult. Consider replacing with larger tube.  
- Check tube cm landmark at nostril or lip  
- Inject air to dislodge tube from mucosa  
- Advance or retract tube 1-2cm  
- Turn infant onto side  
- Use smaller syringe  
- Seek assistance  
- Replace tube | A larger diameter syringe creates less pressure when aspirating  
- Seek advice from a CRN, CSN, CNL, and/or physician |
- Gastric aspirate can be clear or cloudy with curdled appearance, off white, white (milky), grassy green, tan, bloody or brown.  
- Small Bowel – golden yellow or brownish green (stained with bile)  
- Respiratory – off white and frothy (mucous stained). |
| 8. Place 0.2 ml of aspirate on the pH strip. | Gastric aspirate pH ≤ 5.5 confirms tube |
placement in the stomach, with gastric colored aspirate.

- Gastric aspirate pH 5.5 or above, with gastric coloured aspirate, consider factors that may contribute to a higher pH include:
  - The presence of amniotic fluid in infant <48 hours old.
  - Medication used to reduce stomach acid. (eg. Ranitidine, Omeprazole).
  - Dilution of gastric acid by enteral feeds. Wait 15-30 minutes for stomach to empty and pH to fall.
  - Some babies will consistently have pH >6.
  - If the above does not apply, seek advice from the health care team.

9. Reinsert (re-feed) remaining aspirate back to infant via NG/OG tube

10. Secure feeding tube position using:
    - Comfeel – protective skin barrier
    - Tegaderm over tube

    ▪ Oral tubes are best secured over the chin, nasal tubes over the upper lip and/or cheek.

11. Dispose of gloves

12. Check NG placement on most recent X-ray

    ▪ Use the opportunity of an X-ray to place/confirm NG/OG position.

13. Enter EVE with infant name/number
    - Click View on tool bar
    - Click Stentor Pac
    - To work Ruler:
      - Right Click
      - Click on measurement
      - Click and drag cursor from diaphragm to end of tube

    ▪ Measure from diaphragm to end of tube
      - 5F: port 1.5 cm from tube end
      - 8F: port 2 cm from tube end

**DOCUMENTATION**

1. BIT
   - Fluid/Nutrition section: record ‘cm’ depth at the lip or nostril

2. Nursing Flow Sheet
   - Daily GI assessment, tick box
   - Record date NG/OG inserted, tick box
   - Write in ‘cm’ depth at the lip or nostril
   - Nutrition, aspirate volume/type
e. Record each pH test result

3. On tube – using red tape
   a. Date of insertion

REFERENCES


APPENDIX

Nasogastric / Orogastric Tube Placement Flow Diagram Appendix A