Aneurin Bevan University Health Board

Insertion and Maintenance of Nasojejunal (NJ) Feeding Tubes in Infants, Children and Young People.

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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Contents

1. Introduction/Overview

Many infants, children and young people (CYP) are unable to meet their nutritional requirements orally, whether it is due to acute illness or chronic disease and as a result they may need clinically assisted nutrition support in the form of enteral tube feeding. Usually this involves a form of feeding directly into the stomach such as a nasogastric (NG) tube or a gastrostomy. However, a small number may require jejunal tube feeding. Jejunal tube feeding is a form of post pyloric feeding where the tip of the tube is placed at least 40cm distally to ligament of Treitz to bypass the stomach (ESPGHAN, 2019).

This policy outlines the use of nasojejunal (NJ) feeding tubes, explaining when they are indicated and how they should be cared for.

2. Statement

This policy is required to guide and support ABUHB staff of the correct procedures to follow when an infant, child or young person requires a NJ feeding tube, the risks involved and how to manage any issues that may be encountered when caring for them. It recognises that these risks can be reduced if correct procedures are followed.

3. Aim/Purpose

To standardise practice throughout ABUHB in order to maintain a high standard of care that is evidence based.
This document will be easily accessible and be available to support professionals caring for CYP with NJ feeding tubes in both the short and long term.

4. Objective

Ensure that all CYP up to the age of 18 years with a NJ tube in ABUHB receive standardised care in all settings. This will be of a high standard and evidence-based to maintain patient safety.

5. Scope

This policy applies to:

- CYP within ABUHB with NJ feeding tubes up until the date of their 18th birthday. The exception is 16- and 17-year-olds on adult wards who would follow the adult guidance in relation to insertion as the practice is different.
- The policy excludes babies on the Neonatal Unit as they use their own All Wales Documentation.
- All staff involved with the insertion of NJ feeding tubes on the paediatric ward (usually Paediatric Advanced Nurse Practitioners

(PANP's), Registrars or Registered Nurses trained and assessed to insert using a blind bedside technique).
- Radiology staff involved in confirming correct position of NJ tube and inserting under fluoroscopy when required.
- All staff involved in managing patients being fed via NJ feeding tubes.
- Healthcare Support Workers within acute and community settings are not currently able to care for NJ tubes.
- Staff who provide training in the methods used to safely confirm correct NJ tube placement and in the safe administration of feeds, water or medicines via a NJ tube.
- Student nurses are currently not allowed to undertake administration of feeds or medication via NJ tube or to insert them, even under supervision (HEIW, 2023a).

6- Roles and Responsibilities

Those responsible for undertaking various aspects of this procedure will be:
- Registered Nurses
- Registered Medical Staff
- Radiology staff
- Suitably trained parents and carers

Parents and carers must have undertaken a period of training and supervised practice in the management of NJ tubes, this will vary from person to person but supervision will continue until the person is assessed as competent by an assessor and the person is confident with their own practice (Appendix 1 & 2) (NICE 2017a). Registered Nurses must attend annual refresher training to maintain their knowledge and skills and must work within the limits of their competence (NMC Code, 2018).

6.1 Person with appropriately assessed competence placing the tube (usually PANP's, Registrars or Registered Nurses):

- Ensure there are no contraindications to the insertion of a NJ tube (refer to section 7.2).
- Explain risks to parent/ carer and infant, child or young person if appropriate and gain verbal consent if is patient able or from parent/carer.
- Complete the NJ Insertion Recording Form – see Appendix 3. Ensure that the type, size, expiry date and brand of NJ tube placed is documented in the patients' medical and nursing notes. Use sticker if available.

- The external length of tube once placement is confirmed should be measured and recorded after placement to help identify any movement of tube. Consider marking the tube with indelible pen at the site of exit at nostril.

  Ensure that the guidelines in section 7.8 regarding the checking of the position of the NJ tube are adhered to and actions undertaken documented.
- To complete the NJ Tube position confirmation and recording form (Appendix 4).

6.2 Medical staff or nurses/ allied health professionals whose role fits within the Professional Framework for Enhanced, Advanced and Consultant Clinical Practice (HEIW 2023b) completing X-ray request forms

- As x-ray is required, the child must be in a hospital setting, this is usually CEAU or the ward. Ensure that the request form clearly requests an extended chest xray and states that the purpose of the x-ray is for NJ tube placement confirmation. (See examples in Appendix 5 & 6)

6.3 Radiographer and Radiologist

- The radiographer acting as practitioner and operator within the Ionising Radiation (Medical Exposure) Regulations (2017) shall ensure that the x-ray request is justified and that the form clearly states that the purpose of the x-ray is to establish the position of the NJ tube.

6.4 Medical staff interpreting X-rays

- Must ensure they are familiar with the interpretation of x-rays following NJ insertion. Guidance on interpretation for Nasogastric (NG) tubes may be found online at the Radiology Masterclass website. This may be required if unable to confirm NG position at bedside.

- https://www.radiologymasterclass.co.uk/tutorials/chest/chest_tubes/chest_xray_ng_tube_anatomy

- Must complete section 11 of the NJ Insertion Recording form (Appendix 3).
- The decision to commence feeding through the NJ tube must be documented in the medical notes, dated, timed and signed.

6.5 Registered Nursing Staff

- Must ensure that the NJ feeding tube is used correctly and in an appropriate manner.
- Must ensure that the NJ tube is cared for correctly to prevent any problems occurring with the tube.
- Must ensure that the guidelines in section 7.8 regarding the checking of the position of the NJ tube are adhered to and actions undertaken documented.
- Must complete the NJ Tube position confirmation and recording form (Appendix 4) and in addition the NJ Insertion Recording form (Appendix 3) if they have inserted the NJ tube.
- Must ensure parents and carers are competent to care for the NJ tube and administer feeds and medications following training and have had a competency assessment prior to discharge home (Appendix 2).

6.6 Dietitian

- To recommend appropriate use of NJ feeding.
- To recommend an appropriate feed and provide a written feeding regime, highlighting the risk of Dumping Syndrome and Refeeding Syndrome (if applicable) in the medical notes.
- To monitor tolerance of NJ tube feeding and adapt regime according to patient's needs and monitoring growth.
- The above applies for acute inpatients and ongoing community support.

6.7 Paediatric Clinical Nurse Specialist (CNS) for Enteral Feeding

- Supports discharge planning by providing training and competency assessment to parents/carers for new patients on the care and management of NJ tube and administration of pump feeds immediately prior to and after discharge from hospital (Appendix 2).
- Is the point of contact for parents and carers regarding concerns about NJ tube when at home in normal working hours. (NICE 2017a)
- Will arrange for admission to Children's Emergency Assessment Unit (CEAU) for the passing of a new NJ tube if the tube is removed during working hours.
- Reviews and assesses the ongoing effectiveness of this policy.
- Can provide training and competency assessment on the maintenance and use of NJ tubes for non-health professionals with prior notice and agreement (Appendix 2).
- Organise training and cascade training for Health Board staff.

6.8 Paediatric Consultant

To undertake regular of review of the child as an outpatient and arrange nutritional blood monitoring as required.

7- Main body

Indications, contraindications and risk assessment

7.1 Indications for NJ feeding

A multi-disciplinary approach should be used when considering if the benefits of jejunal feeding outweigh the risks. This should always include a consultant, dietitian, specialist nurse, and speech and language therapist and psychologist as required. Discussions should always be had with the patient and family in advance to ensure that informed consent can be obtained (ESPGHAN/ Broekaert et al, 2019). The benefits and risks of both placement and ongoing use of the NJT must be shared in these discussions. These discussions should be documented clearly and shared with all relevant professionals.

Oral or gastric feeding should always be the preferred route of feeding wherever possible and safe. NJ tube feeding may need to be considered if a CYP is unable to meet fluid and nutrient requirements via a gastric route and a variety of management options have been trialled such as; feed and regimen changes, medication alterations, trial of pro-kinetics, proton pump inhibitors or anti-emetic medications if appropriate and a Speech and Language swallow assessment. ESPGHAN/ Broekaert et al, 2019 also recommend considering upper GI endoscopy and contrast meal and follow through prior to jejunal feeding to look for any potential obstructions or GI abnormalities.

Indication
Poor tolerance of gastric feeds/ intractable vomiting
Absent gag reflex
Severe reflux with faltering growth
Severe reflux with aspiration of gastric contents
Gastric dysmotility
Gastric outlet obstruction
Delayed gastric emptying

Regular assessment should be taken to evaluate whether the CYP is able to be progressed in their method of feeding, i.e. gastric/oral.
Consideration should also be given to early referral for a more permanent

feeding route such as gastrostomy +/- fundoplication or gastrojejunal tube.

7.2 Contraindications for NJ feeding

Practitioners will have different levels of experience in placing NJ feeding tubes. There are very few CYP with absolute contraindications however there are some relative contraindications which will dictate the required level of experience and/or speciality of the person placing the NJ tube. In some circumstances the NJ tube may need to be placed under fluoroscopy or even in a tertiary centre. Contraindications may include:

- Basal skull fractures
- Maxillofacial disorders
- Unstable cervical spinal injuries
- Nasal/ pharyngeal /oesophageal obstruction
- Choanal atresia
- Tracheoesophageal fistula
- Oesophageal abnormalities or have undergone oesophageal surgery.
- Actively bleeding oesophageal or gastric varices
- Gastric outflow obstruction
- Intestinal obstruction
- Extensive short gut

(NNNG, 2023)

A multidisciplinary team decision should be made in such individual cases.

7.3 Risk assessment prior to NJ tube insertion

Before a decision is made to insert a NJ tube, an assessment should be made to identify if NJ feeding is appropriate for the CYP. A decision needs to be made that balances the risks with the need to feed. Actions to reduce risks and the rationale behind these actions should be documented prior to the commencement of feeding. This information will support staff in making the correct clinical decisions.

- The decision to insert a NJ tube for the purpose of long-term feeding at home must be made following careful assessment of the risks and benefits by the Consultant Paediatrician, dietitian and clinical nurse specialist responsible for the patient's care.
- The details of this assessment and actions to reduce all identified risks must be recorded in the CYP's medical notes prior to insertion of NJ tube and commencement of feeding.

- As a minimum, documentation should include signed, dated and timed entry of the process of the initial risk assessment.

CYP who are unconscious or semi-conscious, have swallowing dysfunction or recurrent retching or vomiting, have a higher risk of placement error or migration of the tube.

NJ tube insertion can be dangerous as well as difficult in CYP with altered anatomy e.g. oesophageal fistula/ pharyngeal pouch or in certain clinical conditions, such as basal skull fracture. In these situations, or if these are suspected, senior clinical assistance should be sought and NJ should only be attempted under fluoroscopic guidance or at tertiary hospital.

7.4 Risk assessing the timing of tube insertion

NJ tubes should not be inserted at night/ out of hours if there are no suitably trained staff available for insertion and confirmation of position. A risk assessment needs to be undertaken with Consultant and dietitian to see if a CYP can safely receive nasogastric (NG) feeds and/ or medication until suitably trained staff are present. If NG is not suitable, consideration should be given to intravenous hydration/ medication. NPSA (2011) have reported a number of errors reported as a result of staff confirming nasogastric tube position out of hours and the same could apply to NJ tubes. There is also no fluoroscopy available out of hours. Therefore, it may be necessary for NJ tube placement to be delayed until competent nursing, medical and radiology staff are available to pass and accurately confirm correct NJ tube placement.

7.5 Overnight Feeding via nasojejunal tube

Because NJ feds need to be given at a slow rate, over long periods of time, feed administration overnight is often required. This carries a risk of tube migration and/or aspiration and potential for tubing to tangle around neck when the CYP is asleep and not under direct supervision. Therefore, it is essential that the paediatric dietitian carries out and documents the overnight feeding risk assessment prior to discharge and ensures that the family understand the potential risks (See Protocol for assessing the potential risks associated with overnight tube feeding in children on SharePoint).

7.6 Type of NJ Tube

NJ tubes are placed via the nostril into the jejunum. They are generally intended for short-term feeding but are often used for longer in certain clinical situations. If they are used for long-term feeding the tube should be passed in alternate nostrils at each change if possible. The tube should be changed as per manufacturer's guidance or sooner depending on integrity of skin on nose or cheek or if nostril becomes sore. A new tube MUST be used every time the tube is placed.

Fine bore (6-8Fr) tubes are routinely used for feeding. They must be categorised as 'single use', be fully radio-opaque and have externally visible centimetre length markings. This enables accurate measurement, interpretation and documentation of their position (NPSA, 2011).
Always check the manufacturer's instructions for how long the tube may remain inserted.

7.7 Admission for initial insertion

Ideally, admission for initial NJ insertion should be planned in advance. This will usually be following a review from the CYP's community Paediatrician and community dietitian. It is imperative that the Ward Patient Flow Co-Ordinator, Advanced Nurse Practitioners, Radiology and Enteral Feeding Team are informed so that admission can be arranged when all parties are available. Once a date is confirmed, it is essential that the ward acute Consultants for that day and ward dietitians are informed. (See Flowchart in Appendix 8).

7.8 Insertion of NJ tube

This procedure must only be undertaken independently if training is completed, and competency has been assessed (Appendix 1) (NICE 2017)

Equipment

- Clinically clean tray
- Fine bore Enfit™ compliant NJ tube of appropriate French size and length
- NPSA compliant pH indicator strips (Currently Johnson Analytica Ltd Avanos aspHirate in Wales, ABUHB Safety Memo, 2022)
- Appropriate tape and hydrocolloid dressing for skin protection unless allergic
- Scissors

- Non-sterile gloves
- Apron
- 10/20ml enteral syringes
- Water for flushing
- Dummy or soother if used
- Tissues
- Receiver
- Disposable tape measure to measure external length
- Indelible pen to mark tube at nostril (if appropriate)
- Oxygen and suction nearby (check both are working)

Procedure

1. Informed oral consent must be obtained for the passing of NJ tube from the CYP and/or their parent/guardian. There may be exceptional emergency situations where prior consent may not be gained.
2. Wash hands as per ABUHB guidance and assemble the equipment ready. Aseptic Non-Touch Technique (ANTT) to be used throughout.
3. Prepare the CYP for the procedure:
    a. Ensure privacy and dignity is maintained
    b. Explain the procedure and rationale to CYP/parent/carer
    c. Assess integrity of skin when selecting nostril

    If no discernible difference you may wish to ask the patient/parent/carer if they have any preference for which nostril to use. Ideally alternate at each tube change.
    a. Position CYP (semi-recumbent on right hand side, head tilted slightly forward)
    b. Agree signal to pause / stop the procedure if appropriate.
4. Wash hands, put on gloves and apron.
5. Examine tube and integrity - ensure guide wire moves freely.
6. The Nasogastric (NG) length required should be estimated first, using the NEX Measurement. Consider the NEMU measurement for small infants as this is validated for use in neonates. (See Appendix 6 ABUHB NG policy, 2023)
7. Then measure the NJ length (see diagram in Appendix 7)
8. Ensure both of these lengths are clearly documented on the NJ tube insertion record (Appendix 3)
9. Apply the hydrocolloid dressing to cheek.
10. If usually used, provide CYP's dummy or soother or offer a glass of water with a straw if appropriate.
11. Insert the tip of the tube into the nostril, along the floor of the nasal passage into the oropharynx and ask the CYP to swallow and tilt chin down slightly if able.
12. Advance the tube gently and encourage the CYP to swallow until the tube reaches the measured NG length.

13. If the CYP shows signs of distress e.g. gasping or cyanosis, pull back the tube a short distance or remove tube. Allow the patient to settle then continue to pass the tube. If the CYP continues with signs of distress, remove the tube immediately and repeat the process. Be aware, gasping or cyanosis may indicate misplacement of tube but **misplacement does not always cause obvious symptoms**.
14. Secure tube to cheek with appropriate tape.
15. Confirm correct position of nasogastric tube using pH indicator strips. PH must be 5.5 or below. Refer to ABUHB NG policy (2023) if unable to obtain aspirate or above 5.5.
16. Administer a water flush (5-10ml depending on tube length).
17. Remove guide wire and keep safe and clean. **The guide wire must never be reinserted unless under visualisation in Radiology.**
18. Once NG position confirmed, insert 2ml water (0.5ml for neonates) to encourage peristalsis then slowly start to advance the tube:

1cm every 15-30 minutes for neonates
2-4cm every 5-10 minutes for infants and small children
4-6cm every 5-10 minutes for larger children.

If any resistance felt, pull back slightly and re-try. NEVER push against resistance.

Flush with 0.5-2ml water with each advancement until NJ distance has been met.

NB. The use of water to aid peristalsis has been helpful in this Health Board, however, other areas undertake the process without and may be necessary in cases of significant fluid restriction.

19. Continue to nurse on right side to allow peristalsis to continue. If possible, wait a few hours before confirming correct placement by extended chest x-ray to allow natural migration of tube. (NICE 2017a). See Appendix 5 for an example form.

20. Tube placement should be confirmed by fluoroscopy screening (if available) or abdominal xray (if out of hours or no radiologist available to do screening) and checked by a senior doctor or radiologist. If no radiologist is available to confirm placement, the patient will need to be admitted for alternative fluid hydration (ie: IV fluids or NG as applicable), until screening can be arranged or competent person available. Correct placement to be recorded in medical notes and section 11 of Appendix 3 to be completed prior to commencing feeds, flushes or medications.

If tube position is not correct, further abdominal xray or fluroscopy screening required (Appendix 6).

21. Ensure NJ insertion form (Appendix 3) is completed and NJ position confirmation and recording form (Appendix 4)

The tube should not be flushed until the NG position has been confirmed in first instance. The NPSA has reported incidents where NG tubes have been flushed with water, which has reacted with the

tube lubricant and provided a false pH reading. NJ feeds/flushes/medication must not be administered until x-ray confirmation of position.

7.9 Confirming NJ tube position

As the jejunum is not a reservoir like the stomach, fluids do not often accumulate to be able to obtain as aspirate as with confirming NG tube position. Therefore, it is important that several checks are made to ensure correct, safe tube position prior to each time the tube is accessed and any time there are concerns about tube position. This should be documented on the NJ tube position Confirmation and Recording Form (Appendix 4).

1.) Ensure the centimetre markings at the nose are correct.

2.) Look for signs of respiratory distress such as coughing, spluttering, colour change.

3.) Has there been any retching or vomiting?

4.) Has the CYP vomited a milk like substance?

Do **not** routinely attempt to aspirate NJ tube as this can cause the NJ tube to collapse or migrate back up to the stomach.

If the CYP is on a continuous feed, these checks should be undertaken every 6-8 hours.

If there are any concerns with the above checks, the pathways in Appendix 9 & 10 should be followed (PIER Network, 2021)

7.10 Securing the tube

A hydrocolloid adhesive dressing such as Duoderm Extra Thin or Comfeel is recommended to be used on the cheek prior to tube insertion to provide a protective layer between the skin and tape, unless there are known allergies to this. The tube should be well secured to the hydrocolloid dressing as close to the nostril as possible, with adhesive tape such as Hypafix, taking care to avoid eye area and lip. This tape should be changed every 1-2 days or when soiled, damp or peeling off. The hydrocolloid layer will need to be changed every 7

days or sooner if soiled, damp or peeling off. The use of adhesive remover wipes can be considered if required and the use of barrier wipes or foam applicators. However, it is essential that these products are fully dry prior to the application of a further adhesive product.

The above regime suits most patients; however, individuals may require different securement products. Currently, nasal bridles are not used within ABUHB Paediatrics, but their use may need to be considered on an individual basis.

7.11 Documentation

The NJ tube Insertion Form (Appendix 3) must be completed each time a new tube is inserted. The NJ Tube Position Confirmation and Recording Form (Appendix 4) must be completed each time a tube position is checked prior to accessing the tube.

7.12 Position of Patient during Feeding

The CYP's position during feeding is important to minimise the risk of reflux, heartburn and aspiration.

- A sitting position is the ideal, or a minimum 30-45° angle during the feed and for 30 minutes following the feed.
- If a patient is fed overnight particular attention needs to be paid to positioning, to minimise aspiration risk. The overnight feeding risk assessment **must** be completed by the dietitian prior to discharge from hospital.

If any signs of shortness of breath, cyanosis, persistent coughing, sudden pallor or increased heart rate are observed the feed should be stopped immediately and medical advice sought.

7.13 Feeding via the NJ Tube

Prior to commencing jejunal feeding for the first time, the risk of Refeeding Syndrome should be considered if the CYP has been malnourished or without feeds, and appropriate action should be taken. Refeeding syndrome can be defined as the 'deleterious clinical and metabolic changes that occur during nutritional support of a severely malnourished patient' (Abbas et al. 2025).

The decision to feed via NJ tube should always be made with the involvement of a paediatric dietitian to establish a suitable feed regime.

Commencement of NJ feeding requires very slow and gradual upwards titration until a tolerable rate and volume is reached. Until this is met, there will be a requirement for NG feeding or IV fluids alongside. The reason for this very slow and gradual titration is to reduce the risk of Early Dumping Syndrome. This is caused by a sudden, large osmotic load in the small intestine which can cause vasomotor and gastrointestinal symptoms (Jain et al, 2019).
NJ feeds should always be administered via a feed pump, never as a gravity or push syringe bolus. A rate of 1-2ml/ minute is usually best tolerated by most children, but the rate is increased gradually to reach this rate. Although most CYP tolerate a rate of 1-2ml/minute, this does vary, and some CYP can tolerate higher rates.

7.14 Hygiene

The jejunum is a sterile environment and does not contain stomach acid to assist in the protection from contamination with bacteria. Therefore, it is essential that strict hand hygiene is undertaken as per ABUHB policy, and that Aseptic Non-Touch Technique (ANTT) is used when accessing the NJ tube (NICE 2017b). Within the hospital setting, all water for the flushing of any enteral syringe should be sterile. For jejunal feeding, it is recommended that water in the home environment is also sterile or cooled and boiled to reduce risk. If NJ feed is disconnected, the sterility of the giving set and feed container is then compromised so a new giving set and feed container must be used. Any decanted or reconstituted feeds must not hang for longer than 4 hours in a hospital setting. In the home, a risk assessment can be undertaken to consider extending this 4 hours, such as overnight.

7.15 Flushing the NJ tube with Water

To prevent blockage, NJ tubes must be flushed with cool boiled or sterile water, using a syringe size no smaller than 10ml, directly after administering feed or medication. It is advisable to administer a flush prior to commencing feed or medication to check tube patency but this may not be suitable for all CYP. Consideration should be given to a pulsatile flushing technique as this may reduce the chance of tube blockage. Once established on NJ feeding, most children tolerate a

rate of 1-2ml/minute but this does vary, and some children can tolerate higher rates.

If pump feeding is suspended or interrupted for a period of time, it is also important to flush the tube on stopping the feed. Feed left to sit within the tube may coagulate and may interact with drugs administered, resulting in tube blockage. With NJ tubes, all water flushes must be sterile water in hospital setting or cool, boiled water at home. It is currently recommended in ABUHB that all syringes are single use only, both at home and in the hospital setting.

7.16 Administration of Medication

Drug absorption can be affected by jejunal administration, all prescriptions need to be checked against the formulary and discussed with the pharmacist and continued as they were via gastric route if deemed to be feasible and safe. Wherever possible medication should be prescribed in a liquid form or a tablet that can be completely dissolved. If available, Proton Pump Inhibitors (PPI's) should be given via gastric route if possible. If not, consider Lansoprazole dissolved in 8.4% Sodium Bicarbonate to help absorption and reduce risk of tube blockage.

Administration of medications via the NJ route is often "off-license" use and as such the prescriber, pharmacist and the person administering take responsibility for the administration, assessment and reporting of any side-effects that the patient may experience.
Absorption and bioavailability of medications administered via the jejunal route may be unpredictable which could increase the risk of adverse effects, and potential reaction with the feeding tube, causing tube blockage (ESPGHAN 2019).

Individual medications should be administered separately. Most CYP tolerate a rate of 1-2ml/minute but this does vary, and some children can tolerate higher rates.
The tube should be flushed with at least 2-5mls of sterile or cool, boiled water before and after each medication is administered. For multiple medications the tube should be flushed with 2-5mls of sterile or cool, boiled water in between each medication (NNNG, 2023). There may be circumstances where CYP are fluid restricted, or neonates and these flush volumes may be reduced.
It is currently recommended in ABUHB that all syringes with jejunal tubes are single use only, both at home and in the hospital setting.

7.17 Tube blockages

Flushing feeding tubes regularly is the simplest way of maintaining their patency and preventing blockages. Pulsatile flushes can be helpful in reducing the risk of blockage.

- If a tube becomes blocked, a new tube will need to be passed. If the end cap becomes stuck, it can be soaked in warm water to see if this will release the cap. Consider using pliers, but be aware that this could damage the tube and cap. If unable to release cap, will need to pass a new NJ tube.
- It is not advisable to attempt to unblock a NJ tube with sparkling water as is sometimes used with gastrostomies.
- Never use a syringe of smaller than 10ml if trying to flush a blocked tube as the increased pressure could cause tube rupture.

Under no circumstances should

- A guide wire be inserted into the NJ tube in an attempt to remove a blockage.
- Carbonated drinks containing sugar or saccharin be flushed through the tube as they precipitate blockages (NNNG, 2023)

7.18 Skin care

Caring for the skin around the tube and tape can help reduce the risk of irritation and infection. Regular checking, at least daily, and cleaning the nostril where the NJ tube is sited may also help prevent irritation and ulceration.

How to care for the skin and nostril:

- Wash hands before and after caring for the tube
- Change tape securing the tube when it is soiled, damp or peeling off
- When changing the tape, cleanse the skin and dry thoroughly
- Try to alter the position of tape when changing it
- Use a hydrocolloid dressing underneath tube to protect from tube pressure and irritation from tape. Alternate the NJ tube between nostrils at each change to prevent ulceration or soreness.
- If skin very sore, consider the use of a barrier wipe prior to applying hydrocolloid dressing.

- Consider the use of adhesive remover wipes, although be mindful that these can cause allergic reactions in some individuals.

7.19 Accidental NJ Tube Removal

In the event of complete tube displacement during working hours (Monday to Friday 09.00-17.00, excluding bank holidays), the Paediatric Enteral Feeding Team can liaise to arrange admission to CEAU (Children's Emergency Assessment Unit) in GUH. Out of working hours, the CYP will need to attend CEAU at GUH where they should have open access for tube changes. If there will be a delay in passing NJ tube, a medical decision will be required to see if the CYP can be managed on NG feeds or will require IV fluids whilst waiting.

7.20 Discharging new patients to the Community setting with a NJ tube

As much notice as possible is required in order to facilitate a safe discharge. Discharge should ideally be avoided on a Friday, weekend or bank holiday as there will be no community enteral feeding nursing or dietetic support available.

- Before discharge the patient /parent/ carer must have received training and be assessed as competent in caring for the tube, administering feed, water and medication. (NICE 2017).
- Ward staff must contact the enteral feeding team to request this training with at least 3 working days' notice.
- Training in care of the NJ tube including pump training, is carried out by the Paediatric Enteral Feeding Clinical Nurse Specialist (CNS). This will be followed by a period of supervised practice from Registered Nurses on the ward. Once a discharge date has been set, the CNS will then return to the ward to undertake a competency assessment prior to discharge. At least 3 working days' notice is required to book this return visit for a competency assessment.
- Open access to CEAU at GUH should be requested prior to discharge in the event of tube displacement or removal. Parents or carers must be aware of how this works.
- Aims and goals of feeding should be clear prior to discharge and a feeding regimen will be provided by dietitian.
- Dietitian should complete the NJ checklist prior to discharge and ensure home delivery service has been set up (Appendix 13)

- The CYP must be discharged with a 7-day supply of feed, syringes, pump feed sets, bottle adaptors (if required), Flocare Containers (if required), tapes and a spare tube which should be supplied from ward stock.
- The CNS will provide 2 pumps, 1 pump bag, 2 pump stands, NJ passport (Appendix 11), NJ information booklet and team contact numbers.
  The nurse discharging the patient must ensure that the patient /parent/ carer is given a copy of the Nasojejunal Tube position confirmation and Recording Form (Appendix 4) for continued use at home.

8. Resources

For the correct implementation of this policy, staff will be required to print and complete a copy of the relevant documentation as described in the policy. These will need to be filed in patient notes. No additional resources are required for the implementation of this policy.

9. Training

The Paediatric Clinical Nurse Specialists (CNS) for Enteral Feeding will keep a training and assessment record of anyone that they train and assess for NJ tube care and administration of feeds. Any non-health carers such as education or care staff will have their competence re-assessed on an annual basis (Appendix 12). This re-assessment is usually undertaken by the CNS's, with the exception of education staff in Special Needs Schools where the School Nurses undertake the competency assessments. In the future, there may be the introduction of cascade training whereby suitably trained and assessed Registered Nursing staff can train and assess other staff for NJ feeding but this has not yet been established.

ABUHB staff will be offered annual enteral feeding updates which will include NJ tubes. Bespoke training can be offered when requested for new staff or those who require a refresher outside of the planned annual updates.

The PANP with ward-based enteral feeding link nurse will keep a training record of anyone they teach and assess to pass NJ tubes.

10. Implementation

This document will be circulated to all relevant clinical areas and will be available on the ABUHB SharePoint.

11- Further Information Clinical Documents

12- Equality

13- Audit

The elements of the policy that will monitor effectiveness and be subject to audit are as follows:

- The correct procedure is undertaken to confirm correct placement of a NJ tube – on insertion and before EVERY use (Section 7.8)
- A NJ tube position confirmation and recording form must be completed for all patients with a NJ tube in situ (Appendix 4)
- Training has been undertaken to ensure staff competencies in relation to the policy (Appendix 1 & 2)

14-Review

This document will be reviewed and updated every 3 years. Amendments will be added if any clinical guidelines change during this time period.

15. References

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Naso Jejunal Insertion Competencies

Assessor Name:

Trainee Name:

Action	Date of Initial training session:		Date of supervised practice:		Date of Assessment of competence:	
	Assessor Sign	Trainee Sign	Assessor Sign	Trainee Sign	Assessor Sign	Trainee Sign
Trainee can explain the reasons why some individuals require NJ feeding.						
Trainee can demonstrate an understanding of the anatomy and physiology in relation to passing an NJ tube.						
Trainee can identify and explain: -Specific risks associated with this procedure -The make of tube being used, care of the tube and how long it can remain in place. -How and when the NJ tube needs to be tested to confirm placement.						
Trainee can demonstrate and explain: -Good hand hygiene -Correct measurement of the NJ tube. -Correct positioning of the child in preparation for passing the tube.						

Paediatric ANP G.Dummett May 23
Review date May 26

Trainee can confidently and safely: -Pass the NJ to the NEX measurement and remove guidewire. -Obtain aspirate and confirm appropriate PH reading to confirm NG placement. - Can explain what action to take if unable to obtain aspirate or aspirate is not within range of acceptable PH.						
Trainee can confidently and safely: - Advance the NJ tube using the appropriate rate and volume of flushes. -Can explain what action to take if unable to advance the tube						
Trainee can demonstrate how to confirm tube placement and secure appropriately.						

Appendix 2- Nasojejunal Feeding: Preparation & Administration via Pump: Initial Competency Sheet

[Type here]

Trainee Name:

Child's Name/DOB:

Nasojejunal Feeding: Preparation & Administration via Pump: Initial Competency Sheet

Minimum of TWO supervised practices to be supervised by a previously assessed person.

	Number & Action	Date of Initial training session:		Date of Supervised practice:		Date of Supervised practice:		Date of assessment of competence:	
		RN sign	Trainee sign	Super visor	Trainee sign	Super visor	Trainee sign	Super visor	Trainee sign
1	Trainee can explain the reasons why some individuals may require Jejunal feeding								
2	Trainee can explain: -Process of preparing the feed - Importance of good hand hygiene -Length of time the feed can hang, how often the giving set needs changing and troubleshoot any difficulties								
3	Trainee can identify & explain specific risks associated with this procedure (ie. potential of milk aspiration or tube displacement) -What to do if the nasojejunal tube becomes dislodged and if the child coughs/chokes/gags/vomits or changes colour during feeding								
4	Trainee can identify & explain: -correct confirmation of nasojejunal tube placement, -why and when to check placement -how to check length of tube								

5	Trainee can confidently and safely: -Prepare feed and set up pump -correctly position child at a minimum 30-degree angle to minimise risk of oesophageal reflux -prime the feed set -set rate and volume on pump as per feed regimen -manage pump alarms								
6	Trainee can explain and demonstrate the need to flush the tube with water before and after feed.								
7	On completion of feed Trainee is aware of standard precautions of infection control and can demonstrate appropriate procedure for cleaning reusable items and disposal/recycling of non -reusable items.								

Action plan/comments
PLEASE NOTE: With the exception of parents/guardians, competence must be re-assessed on an annual basis or sooner if any concerns are raised. Please contact the team to arrange this on 01633 748056/ 748057. Parents/guardians will have competence discussed and reviewed at their child's annual review. **To maintain skill and competence, the trainee should undertake the skill on a regular basis, ideally at least weekly.**

Trainee and Nurse Assessor must sign below prior to carrying out nasojejunal feeds without supervision

Trainee	**Print name, signature & date**	**Nurse assessor**	**Print name, signature & date**
I have received training and been assessed as competent. I am willing to undertake nasojejunal pump feeding without supervision. I will not allow anybody to feed the named child via the nasojejunal tube unless trained and assessed to do so by the Paediatric Enteral Feeding Team.		The named person has received training to carry out nasojejunal pump feeding for the above named child and has been assessed as competent to carry out the procedure unsupervised.	

Appendix 3- Nasojejunal (NJ) Tube Insertion Recording Form

Nasojejunal (NJ) Tube Insertion Recording Form

Patient Addressograph

1. Date and time NJ tube inserted	Date: Time:
2. Rationale/ reason for inserting NJ tube	
3. Inserted by	Name (block capitals): Job Title: Signature:
4. Number of attempts	
5. Tube details	Tube manufacturer: Short or long term: Length and French size of tube: LOT no: Expiry date:
6. NEX and NJ measurement in centimetres	NEX..... NJ.....
7. Aspirate obtained?	❑ Yes (proceed to step 8.) ❑ No (Refer to Appendix 8 of NG policy)
8. Check pH reading of aspirate	❑ pH 5.5 or less (proceed to 9) ❑ pH 6 or more (Refer to Appendix 8 of NG policy)
9. Is the NG tube safe to use at this time?	❑ Yes ❑ No (Refer to appendix 8 of NG policy)
10. Able to advance to NJ length as per section 7.8 of NJ policy?	❑ Yes (continue to step 11) ❑ No (STOP if resistance felt)
11. Correct position of NJ confirmed by extended chest xray or fluroscopy by Doctor or Radiologist	❑ Yes ❑ No Name (block capitals): Job Title: Signature:

Appendix 4 - Nasojejunal (NJ) Tube Position Confirmation & Recording Form

Insertion and Maintenance of Nasojejunal Feeding Tubes in Infants, Children and Young People- Policy Toolkit- Appendix 4 .

Nasojejunal (NJ) Tube Position Confirmation & Recording Form

Addressograph or Name: DOB: CRN:

It is mandatory to check child and NJ tube:

1. **following initial insertion**
2. **before administering each feed**
3. **before giving medication**
4. **at least every 6-8 hours during continuous feeds**
5. **following episodes of vomiting, retching, coughing, colour change**
6. **following evidence of tube displacement (for example, loose tape or visible tube appears longer)**

Date/time tube inserted	Tube inserted by 1. Name 2. Job Title	Type of tube	Centimetre marking at nose or external tube length	Date tube removed and reason

Date	Time	Checked by *Name *Job title	Centimetre marking at nose or external tube length	Any concerns re NJ tube displacement or movement	Safe to commence feed? Yes or No

ABUHB Paediatric Enteral Feeding Team

Document date October 2024

Appendix 5- Example radiology request form for initial NJ placement check

RADIOLOGICAL IMAGING REQUEST FORM

(Hospital Telephone Numbers on Reverse)

Patient's addressograph or print

Surname: MOUSE D.O.B: 1.1.11

Forename(s): MICKEY

Address: 2 DISNEY TERRACE
WALT DISNEY

Post Code: W1 D1

Patient Tel No: 123 456 789

NHS No: 999 999 999

Hospital No: 111 111 Radis No:

Consultant: DR SEUSS

Patient Mobility

Walk ☐ Ambulance ☐
Chair ☑ Hoist ☐
Trolley ☐ Escort Yes/No
Bed ☐ Portable ☐

Priorities

USC ☐ Urgent ☑
Routine ☐

Deferred Date: .....

Patient Category

GP Practice ☐ IP ☑ Clinical Trial ☐
Ward C1 PAEDS ☐ OP ☐ Private ☐

Any Past History Of:

Contrast Reaction ☐
Inoculation Risk e.g.Hep B

Allergy ☐
Latex ☐
Diabetes ☐

Date of LMP / / Deaf ☐ Interpreter ☐

~~eGFR .....~~
~~Test Date / /~~
~~Normal Result acceptable for 3 months~~
N/A

eGFR **MUST** be completed for a contrast examination or **form will be returned**.
If **ab**normal confirm that benefits of the procedure (including the administration of contrast) out weigh the risks detailed below by choosing Yes
(main risk - a deterioration in renal function) Print Name: .....
Esp eGFR **<30** when liaison with a hosp team / day unit for IV fluid administration
eGFR **30 - 60** oral fluid required in Radiology Department
Renal function in these circumstances needs checking after 72 hrs after the examination

Include All Clinical details and what information is expected from the examination?
(You are legally obliged under IRMER 2017 to supply sufficient medical data to justify this medical exposure and read the report.)

Examination Requested

EXTENDED CHEST XRAY

NEW NJ TUBE INSERTED. XRAY FOR TUBE PLACEMENT CONFIRMATION

FOR X-RAY USE ONLY

No. Images

Comments / Isotope Information:

Referring GP address

Form completed by (Print Name in Capitals):
Signature: Date:
Status (please circle) NMR / F1 / F2 / CT1 / SG / SpR / Cons / GP
Bleep / Contact No:

DOUBLE CHECK PATIENT'S NAME AND IDENTIFIERS ARE CORRECT **FOR X RAY ONLY**

Examination justified by practitioner: (Signature Date)

Operator's Responsibility:
I have identified the patient by checking the patient's name, address and DOB

Is the patient pregnant? Yes ☐ No ☐ Date of LMP
Pregnancy Test: Negative / Positive / Not Applicable
Breast Feeding? Yes ☐ No ☐

Operator (Signature):

Appointment Details

Attach Radiology Bar Code Label Here

Vetting Category: Urgent/Future/Routine/Appointment

No Images / exposures: Dose: Screening Time:

Appendix 6- Example radiology request form for re-check of NJ placement.

RADIOLOGICAL IMAGING REQUEST FORM

(Hospital Telephone Numbers on Reverse)

Patient's addressograph or print

Surname: MOUSE D.O.B: 1.1.11

Forename(s): MICKEY

Address: 2 DISNEY TERRACE
WALT DISNEY

Post Code: W1 D1

Patient Tel No: 123 456 789

NHS No: 999 999 999

Hospital No: 111 111 Radis No:

Consultant: DR SEUSS

Patient Mobility

Walk ☐ Ambulance ☐
Chair ☑ Hoist ☐
Trolley ☐ Escort Yes/No
Bed ☐ Portable ☐

Priorities

USC ☐ Urgent ☑
Routine ☐

Deferred Date: .....

Patient Category

GP Practice ☐ IP ☑ Clinical Trial ☐
Ward C.I. PAEDS ☐ OP ☐ Private ☐

Any Past History Of:

Contrast Reaction ☐
Inoculation Risk e.g.Hep B

Allergy ☐
Latex ☐
Diabetes ☐

Date of LMP / / Deaf ☐ Interpreter ☐

eGFR .....
Test Date / /
Normal Result acceptable for 3 months
N/A

eGFR **MUST** be completed for a contrast examination or **form will be returned**.
If **ab**normal confirm that benefits of the procedure (including the administration of contrast) out weigh the risks detailed below by choosing Yes
(main risk - a deterioration in renal function) Print Name: .....
Esp eGFR **<30** when liaison with a hosp team / day unit for IV fluid administration
eGFR **30 - 60** oral fluid required in Radiology Department
Renal function in these circumstances needs checking after 72 hrs after the examination

Include All Clinical details and what information is expected from the examination?
(You are legally obliged under IRMER 2017 to supply sufficient medical data to justify this medical exposure and read the report.)

Examination Requested

EXTENDED CHEST XRAY

NJ TUBE ALREADY INSITU.
TUBE ADJUSTED SINCE LAST
CHECK XRAY

FOR X-RAY USE ONLY

No. Images

Comments / Isotope Information:

Referring GP address

Form completed by (Print Name in Capitals):

Signature: Date:

Status (please circle) NMR / F1 / F2 / CT1 / SG / SpR / Cons / GP

Bleep / Contact No:

DOUBLE CHECK PATIENT'S NAME AND IDENTIFIERS ARE CORRECT **FOR X RAY ONLY**

Examination justified by practitioner: (Signature Date)

Operator's Responsibility:

I have identified the patient by checking the patient's name, address and DOB

Is the patient pregnant? Yes ☐ No ☐ Date of LMP

Pregnancy Test: Negative / Positive / Not Applicable

Breast Feeding? Yes ☐ No ☐

Appointment Details

Attach Radiology Bar Code Label Here

Operator (Signature):

Vetting Category: Urgent/Future/Routine/Appointment

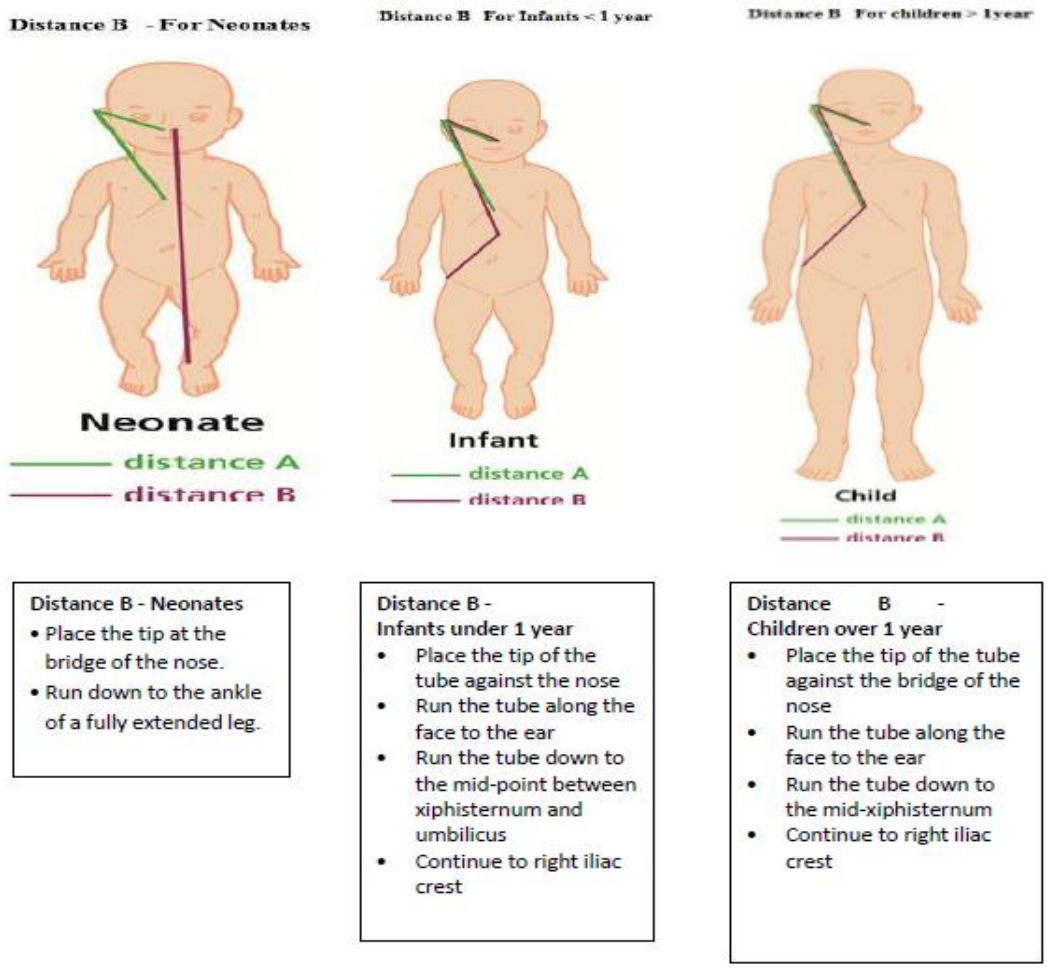
No Images / exposures:	Dose:	Screening Time:

Appendix 7 Measurement of NJ tube length

- It is important to determine the length of NJ tube required to reach the jejunum prior to insertion. This should be done in two measurements A and B:
- Distance A: This is the NEX measurement (nose, ear, xiphisternum) as per a nasogastric tube
- Distance B: The length of tube required to place an NJ tube in the small bowel. See pictures below for the different age groups. Oral jejunal tubes should be measured from the mouth and not the nose for all age groups. The measurements are obtained as follows:

Both lengths should be clearly documented in the patient notes.

Distance B (is measured according to age)



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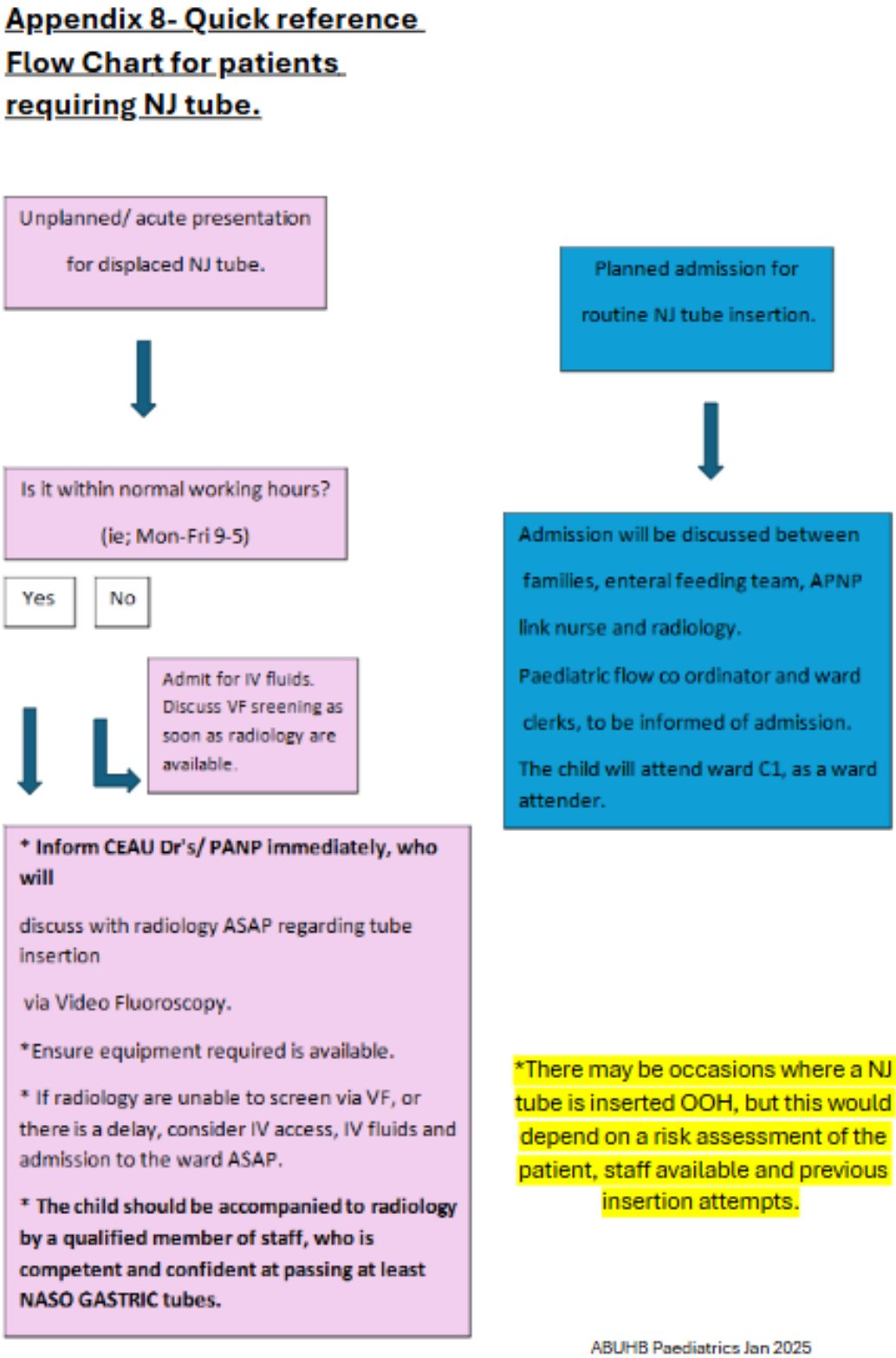
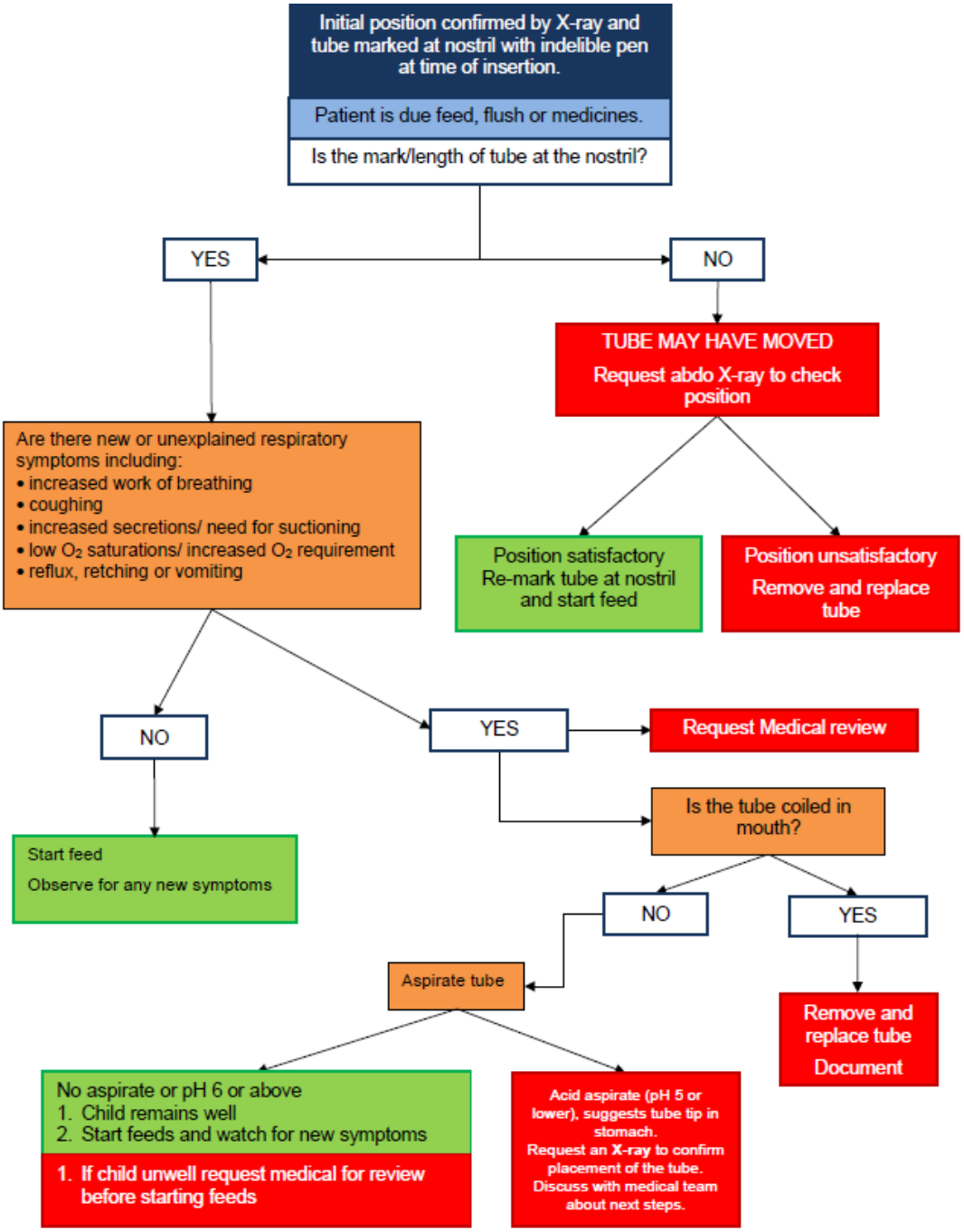
Appendix 8- Quick reference Flow Chart for patients requiring NJ tube.



Appendix 9 - Nasojejunal Tube Position Check Pathway (Inpatient)
Document All Decisions and Actions



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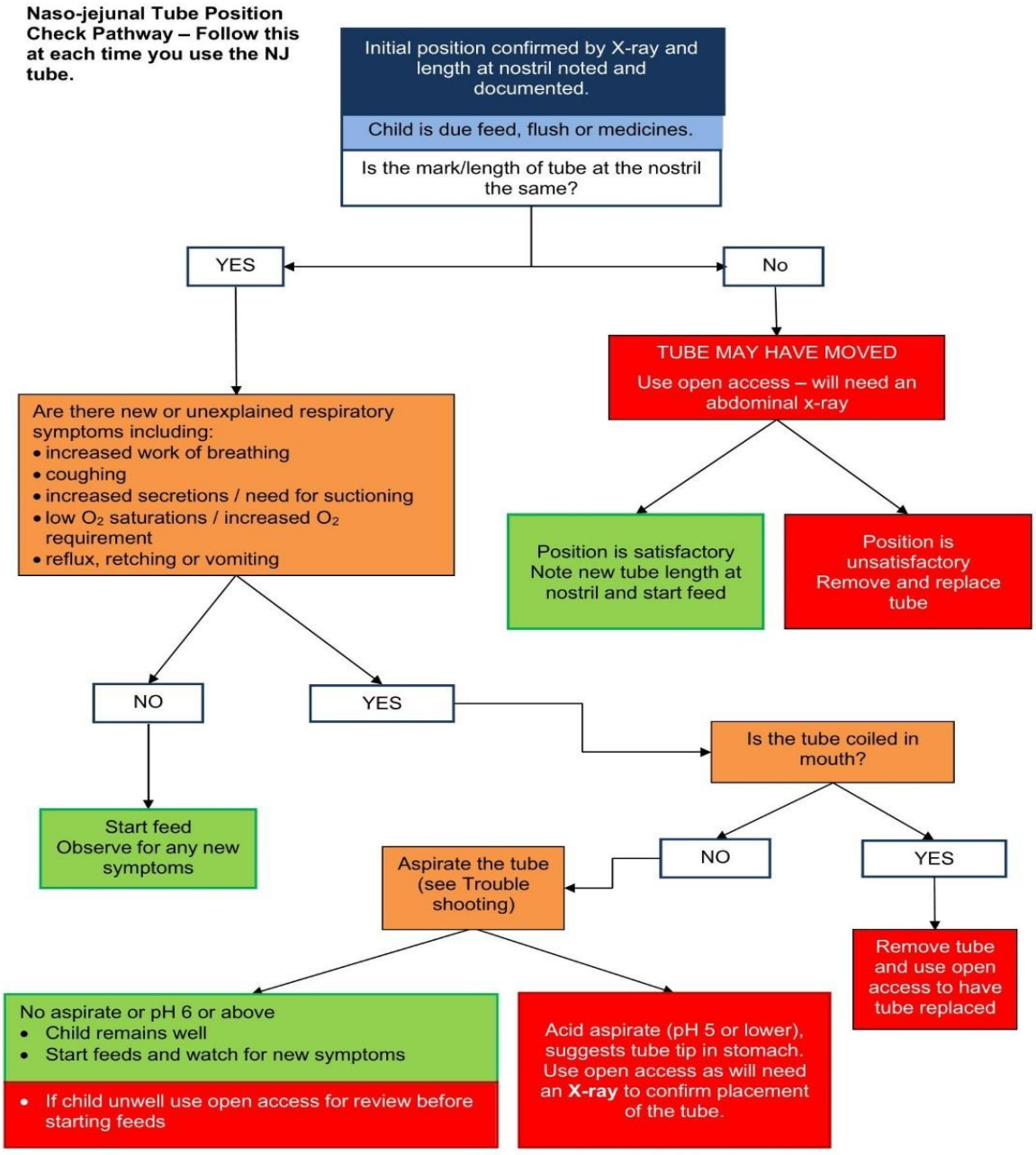
Appendix 10- Nasojejunal Tube Position Check Pathway (home use)



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Appendix 11- NJ passport

My Nasojejunal (NJ) Tube Passport

Addressograph

Parent/Carer name:

Parent/Carer telephone number:

Consultant:

NJ tube type and size:

About me/ Medical History:

(It is important to note if I have an unsafe swallow and if I am at high risk of aspiration)

Management of my NJ tube if it comes out or there are any concerns about its position

I have a NJ tube which is essential for my nutrition, hydration and medication. If my NJ tube comes out or there are concerns about its position, it is important that my parents or carers take me to CEAU at The Grange University Hospital for a replacement tube as soon as possible. Before I attend, my parent or caller will call ahead on 01633 493139 to advise that I will be coming in. It is important that I bring this passport, a spare NJ tube, my preferred tapes and my usual feed and medications.

CEAU staff:

When I attend the hospital, please inform a Paediatric Advanced Nurse Practitioner. They will arrange for me to have a new tube passed. Please also speak to Radiology as I will need fluoroscopy to confirm the position of my tube once passed. If it is out of hours, I will need an x-ray to confirm position. If my tube is correctly sited and I have not been off my feeds for too long, I can go straight home. If I have been a long time without feeds, I may need to stay in hospital to gradually re-introduce my feeds/fluids. This will need to be decided by a consultant and dietitian.

If my tube is not correctly sited, I will need to stay in hospital for fluoroscopy the next day. I will need IV fluids and medications to keep me hydrated.

A doctor *may* assess that it is safe for me to have a nasogastric (NG) tube overnight for fluids and medications instead of intravenously. It is important for the hospital staff to check that my parent or carer has been assessed as competent to manage a NG tube if I am to be sent home. If they have not, I must remain in hospital for the staff to care for the NG tube and administer my feeds, flushes and medications.

It is essential that I am NOT discharged home without a means of administering my feeds, fluids and medications. If I attend at night and nobody is available to pass my NJ tube, I will need to be admitted for IV fluids and medications as above, or a doctor *may* assess it is safe for me to have a NG tube overnight.

Appendix 12- Nasojejunal Feeding: Preparation & Administration via Pump: Continuation sheet for yearly competency reviews and assessments

Trainee Name:

Child's Name/DOB:

Nasojejunal Feeding: Preparation & Administration via Pump: Continuation sheet for yearly competency reviews and assessments

	Number & Action	Date		Date		Date		Date:	
		RN sign	Trainee sign	RN sign	Trainee sign	RN sign	Trainee sign	RN sign	Trainee sign
1	Trainee can explain the reasons why some individuals may require Jejunal feeding								
2	Trainee can explain: -Process of preparing the feed - Importance of good hand hygiene -Length of time the feed can hang, how often the giving set needs changing and troubleshoot any difficulties								
3	Trainee can identify & explain specific risks associated with this procedure (ie. potential of milk aspiration or tube displacement) -What to do if the nasojejunal tube becomes dislodged and if the child coughs/chokes/gags/vomits or changes colour during feeding								
4	Trainee can identify & explain: -correct confirmation of nasojejunal tube placement, -why and when to check placement -how to check length of tube								

5	Trainee can confidently and safely: -Prepare feed and set up pump -correctly position child at a minimum 30-degree angle to minimise risk of oesophageal reflux -prime the feed set -set rate and volume on pump as per feed regimen -manage pump alarms								
6	Trainee can explain and demonstrate the need to flush the tube with water before and after feed.								
7	On completion of feed Trainee is aware of standard precautions of infection control and can demonstrate appropriate procedure for cleaning reusable items and disposal/recycling of non -reusable items.								

Action plan/comments (Trainee and assessor to sign below yearly if competence is achieved at assessment)
PLEASE NOTE: With the exception of parents/guardians, competence must be re-assessed on an annual basis or sooner if any concerns are raised. Please contact the team to arrange this on 01633 748056/ 748057. Parents/guardians will have competence discussed and reviewed at their child's annual review**. To maintain skill and competence, the trainee should undertake the skill on a regular basis, ideally at least weekly.**

Appendix 13 – Discharge Checklist

Name
Address
DOB
Hospital / NHS Number

DEPARTMENT OF

NUTRITION & DIETETICS –

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Dietitian checklist for discharging paediatric patients with a NEW NG/NJ tube/placement

Circle tube type: NG NJ

Check details with parents / carers	Initial & date or N/A
Parents / carers names and relationship to patient:	
Telephone numbers for all parents/carers -double check with parent/carer:	
Email addresses for all parents / carers:	
Home address:	
Alternative addresses for deliveries: 1. 2. 3.	
GP address:	
Social worker contact details:	
Social circumstances / considerations:	
Homeward Service Discuss with parent/carer and obtain consent to register with Homeward	

Feed Supply: Establish where patient would like to obtain feed from: **Local pharmacy OR Homeward** Only include feed on Homeward registration if delivery is required from Homeward. If feed to be obtained locally ensure parent/carer is aware of procedure.	
Complete patient registration on Nutricia Connections Registration needs to be completed as soon as possible and can be completed by DSW. Patients can be **'saved as draft'** until discharge date is finalised.	
Ensure parent/carer has been trained AND signed off by HEF (Home Enteral Feeding) nurses Ward nursing staff or dietitian can refer to HEF nurses.	
Ensure ward are aware of equipment required for home Provide ward with equipment list. Patients require adequate supplies of feed and ancillaries for 7-10 days. However, if discharge occurring prior to a Bank Holiday additional supplies may be required. Homeward can deliver 2 or 5 working days post discharge.	
If pump feeding- Obtain pump number for homeward: _____	
Provide patient with feed regime To include volumes of feed, method of administration, rate and flushes	
Ensure feed regime is on CWS and in patient folder in patient's HEF folder ABB Family & Therapies ■ Acute Paediatrics & Medics - HEF Patient Files - All Documents (sharepoint.com)	
Consider overnight risk assessment ABB Family & Therapies ■ Acute Paediatrics & Medics - ABUHB_F&T_0491 Protocol for Assessing the Risks of Overnight Tube Feeding in Children_Issue 2.pdf - All Documents (sharepoint.com) To be completed for ANY patient that is feeding overnight **Save on CWS and in patient folder**	
Ensure long term tube has been passed prior to discharge	
Complete letter to GP Inform of new NG/NJ placement Request feed via WP10 Upload letter to CWS	
Send this document as handover via email to HEF Dietitians and telephone handover if appropriate Email: HEFPaediatricDietetics.ABB@wales.nhs.uk	
Save checklist document in patient folder	

Name

Address

DOB

Hospital / NHS Number

DEPARTMENT OF NUTRITION & DIETETICS –
ANEURIN BEVAN UNIVERSITY HEALTH BOARD

List of equipment required for discharging paediatric patients with a NG/NJ tube.

Circle tube type: NG NJ

TO BE SUPPLIED BY WARD	
Item	**Quantity**
Feed **Feeding syringes** (Single use for NJ) **Flocare Universal Adapters** Required for any patient using baby bottle, sterifeed bottle, ONS or abbott feed. **Giving sets** (Only required if pump feeding) Will be required for all patients with NJ tube **Gravity Bolus set OR syringes** For any patient not pump fed **PH indicator strips** **Tape to secure NG/NJ tube** **Medication syringes**	Minimum of 7 day supply *If discharge occurring prior to a Bank Holiday additional supplies may be required* *If any issues with lack of stock – please contact Dietitians asap*
Spare NG/NJ tube	x 1

HEF NURSES WILL SUPPLY THE FOLLOWING	
Item	**Quantity**
Infinity Feeding pump (Only required if pump feeding) Will be required for all patients with NJ tube	x 1 pump for NG feeding x 2 pumps for NJ feeding
Go stand and backpack (Only required if pump feeding) **HEF nurses contact numbers** **Prescription request form for GP for tapes and adhesive remover wipes**	N/A

Place this sheet in bed end notes for nursing staff to use as guide for discharge