East Midlands Neonatal
Operational Delivery Network

GOOD PRACTICE POINTS:
CARE OF A BABY REQUIRING INSERTION OF A NASOJEJUNAL TUBE

Introduction

Naso-jejunal tube (NJT) feeding is an alternative method of providing enteral nutrition to a neonate with severe gastro-oesophageal reflux (GOR) disease and/or at risk of significant aspiration events related to reflux. NJT feeding may also be used for neonates with structural problems of the oesophagus or stomach.

Scope of Practice

These good practice points have been produced for the use of nursing and medical staff working in Neonatal Units across the East Midlands Neonatal Operational Delivery Network (EMNODN). They are intended to support a consistent approach to the insertion of an NJT and the care of the baby with an NJT across the Neonatal units within the EMNODN.

Good Practice Points

- The decision to commence feeding via an NJT should be made by medical staff.
- Parents/carers should be informed of the decision to insert the NJT and the rationale for that decision.
- The NJT may be placed in the fridge for 30 - 60 minutes before insertion, as this can make it slightly stiffer and theoretically easier to site.
- Measurement should be taken from the bridge of the nose to the outstretched heel. This is the length for placement of an NJT. This measurement should be documented and marked on the NJT prior to insertion. This measurement must always be checked when replacing the NJT. The length for insertion of the tube into the stomach should also be noted.
- During insertion of the NJT, cardiac monitoring should be carried out to observe for any irregular heart rhythm caused by vagal nerve stimulation. The infant should also be observed for any signs of cyanosis, respiratory distress or apnoea.
- Standard hand hygiene procedures should be followed and non-sterile gloves used during the procedure.

- The NJT should be passed via the nostril into the stomach. The pH must be checked in line with guidelines for the insertion of a nasogastric tube (NGT) to confirm the position of the NJT in the stomach.

- When it is confirmed that the NJT is in the stomach the tube should be advanced slowly (a few centimetres every 5 minutes) until the required tube length (as marked) is reached. This will enable natural peristalsis to aid progression of the NJT beyond the stomach. The NJT must never be advanced against resistance due to the risk of injury or perforation.

- When the measured distance has been reached the NJT should be secured in place. The tube should be aspirated and the pH of the aspirate checked to ensure an alkaline reaction is obtained.

- The date and time of insertion, the feeding tube size, insertion length, batch number and initial pH should be documented in the patient record.

- The NJT should be clearly labelled.

- A naso- or oro-gastric tube (NGT/OGT) should be passed to facilitate aspiration of the stomach and the administration of medicines.

- **The NGT/OGT should be clearly labelled to avoid confusion with the NJT.**

- The position of the NJT must be confirmed by abdominal X-ray.

- Feeding should not begin until the tube position has been confirmed.

- Confirmation of the NJT position and the decision to commence feeds should be documented in the patient record by medical staff.

- Feeding via an NJT should be by continuous infusion. This is because the feed is being delivered into the small bowel, which has little capacity for storage.

- NJT feeds should be started slowly and gradually increased to full feeds over 24 to 48 hours. This helps the jejunum adapt to acquiring all feed directly with no progression from the stomach.

- Medications should be administered directly into the stomach unless otherwise indicated. This is because most medications require activation by gastric acid. Advice from a neonatal or paediatric pharmacist is recommended.

- Thickened feeds should not be given via an NJT.

- The type of feed and volume given should be recorded hourly.

- The NGT/OGT should be aspirated every 4 hours to check for the presence of milk in the stomach. This could indicate the NJT has moved back into the stomach and the tube may need to be repositioned or a new tube passed.

- The NJT should not be aspirated as this can cause collapse and recoil of the tube.

- The infant should be observed for signs of abdominal discomfort, distension, visible loops of bowel and/or necrotising enterocolitis.

- The NJT should be changed regularly in line with the manufacturer's instructions.

Auditable Standards

	Auditable Standard	Target
1	The decision to commence feeding via an NJT is documented by medical staff	100%
2	A neonate with an NJT in situ also has an NGT or OGT inserted	100%
3	The NJT and NGT/OGT are both clearly labelled	100%
4	The length for the insertion of the NJT is documented	100%
5	The date and time of NJT insertion, the feeding tube size, insertion length, batch number and initial pH are documented	100%
6	There is documentation that the position of the NJT has been confirmed by medical staff	100%
7	The decision to commence feeds has been documented	100%
8	The NGT/OGT has been aspirated 4-6 hourly and results documented	100%
9	The NJT has been changed in line with manufacturer's instructions	100%

References

Cirgin-Ellett, M.L., Beckstrand, J. (2007). *Predicting the distance for Naso-jejunal Tube Insertion in Children.* Journal of Specialists in Pediatric Nursing. [Online]

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Phipps, L.M., Weber, M.D., Ginder, B.R., Hulse, M.A., Thomas, N.J. (2005). *A randomised controlled trial comparing 3 different techniques of naso-jejunal feeding tube placement in critically ill children.* Journal of parenteral and enteral nutrition. 29 (6), 420 – 422.

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