

SOP on Nasogastric (NG) Tube Feeding

Department of Family Medicine

Faculty of Medicine

UWUSL

Standard Operating Procedure (SOP) for Nasogastric (NG) Tube Feeding

Issued By

Faculty of Medicine, Uva Wellassa University of Sri Lanka

1. Purpose

To provide a standardized and safe method for administering enteral nutrition via a nasogastric tube, ensuring adequate nutrition while minimizing complications.

2. Scope

This SOP applies to medical students, nurses, and healthcare professionals involved in enteral feeding in hospital and primary care settings.

3. Responsibilities

3.1 Students / Healthcare Assistants

- Assist in preparation and feeding procedure
- Maintain hygiene and aseptic technique
- Observe and report any complications

3.2 Nursing Staff

- Verify tube placement before feeding
- Administer feeds safely
- Monitor patient tolerance

3.3 Medical Officers

- Prescribe type, volume, and rate of feeding
- Manage complications

4. Safety Consideration

- Perform hand hygiene before and after the procedure
- Use clean/aseptic technique
- Confirm correct patient identity (right patient, right feed, right route, right rate)
- Always verify NG tube placement before feeding
- Maintain patient in semi-upright position (30–45°)
- Stop feeding if the patient develops coughing, choking, or respiratory distress
- Ensure safe handling & storage of feeds

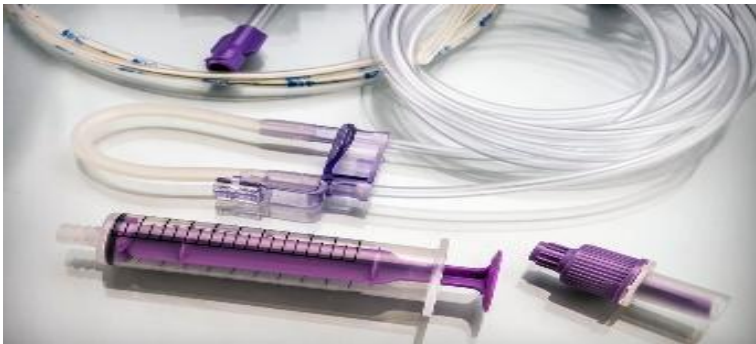
5. Materials Required

- NG tube



- Prescribed enteral feed

- Feeding syringe or feeding set



- Clean water for flushing



- Stethoscope



- Kidney tray



- Gloves



- pH indicator strips



- Towel or protective sheet

6. Procedure

6.1 Preparation

- Consider doctor's prescription (type, volume, frequency of feed)
- Identify the patient correctly
- Explain the procedure and request consent
- Perform hand hygiene and wear gloves
- Position patient in semi-Fowler's position (30–45°)



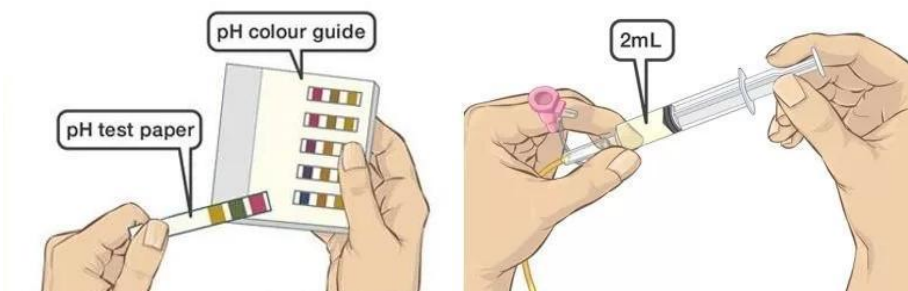
6.2 Verification of Tube Placement

- Aspirate gastric contents using a syringe

- Check pH (≤ 5 suggests gastric placement)



- Assess colour and consistency of aspirate



- Do not proceed if placement is uncertain

- Do not rely only on air insufflation method



6.3 Feeding Procedure

- Flush the tube with 20–30 mL of water
- Attach feeding syringe or set
- Administer feed slowly by gravity (do not force)



- Maintain a steady and controlled rate
- Avoid contamination during feeding

6.4 After Feeding

- Flush the tube with water to prevent blockage
- Clamp or close the tube



- Keep the patient in upright position for at least 30 minutes

7. Monitoring

- Observe for nausea, vomiting, or abdominal distension
- Monitor for coughing, choking, or breathing difficulty
- Watch for signs of aspiration
- Check tube patency and position regularly
- Assess patient tolerance to feeding

8. Records and Documentation

- Record patient identification details
- Document type and amount of feed given
- Note date and time of feeding
- Record patient response and any complications
- Document any actions taken

9. Post-Procedure Care

- Dispose of waste according to infection control guidelines
- Clean and store equipment properly
- Remove gloves and perform hand hygiene
- Ensure patient comfort

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