

**PARKLAND HEALTH & HOSPITAL SYSTEM
LEADERSHIP & ORGANIZATIONAL DEVELOPMENT**

**COMPETENCY VALIDATION
SMALL BORE FEEDING TUBE INSERTION**

Name: _____ ID#: _____

Unit: _____ Date: _____

Small bore feeding tube insertion	1st Attempt (P or F)	2nd Attempt (P or F)	Comments
1. Check physician's orders: (Including order for KUB to confirm placement and possibly Reglan.)			
2. Gather equipment: Small-bore feeding tube, tape, stethoscope, 50 ml or larger luer tip syringe, alcohol prep pads, benzoin swab, tap water, cup, gloves.			
3. Wash hands (can verbalize). Glove.			
4. Identify patient (two identifiers). Explain procedure to patient. Remove dentures.			
5. Position patient upright, at least 30°, unless contraindicated.			
6. Seat the stylet, close side port on feeding tube.			
7. Flush tube with water using 50 ml luer syringe.			
8. Dip tip of tube in water to lubricate.			
9. Measure tube (from tip of nose to earlobe to then to xiphoid process - then add 9 inches) – mark tube.			
10. Insert tube from nare to back of throat, then have patient take sips of water to facilitate swallowing as tube is inserted to the predetermined mark. a. If resistance encountered, remove tube and attempt reinsertion. b. If resistance encountered after passage through epiglottis, pull back and rotate slightly then re-advance tube if no resistance. c. If resistance continues, remove tube and consult with charge nurse or unit manager. If unable to insert tube, notify LIP. d. If patient coughs excessively, remove tube immediately and attempt reinsertion when patient comfortable.			
11. Cleanse nose with alcohol prep; apply Benzoin.			
12. Secure tube with tape.			
13. Check placement: a. Inject air into tube with syringe while auscultating over epigastrium (listen over several areas before determination tube is misplaced). If unable to auscultate, remove and reinsert tube.			
14. Remove stylet. a. Patient may be placed on right side to facilitate passage of tube into duodenum. b. If Metoclopramide ordered, administer. c. Never reinsert stylet into patient after removal to prevent perforation of esophagus or GI tract.			
15. KUB x-ray ordered - time for 4-24 hours after insertion for confirmation of placement.			
16. Ensure patient comfortable, replace dentures, remove gloves, wash hands.			

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17. Document date and time inserted, tube size and length inserted, KUB ordered, tolerance of procedure, and patient teaching. Later, document post-pyloric placement verified by KUB.			
18. After verification of post-pyloric placement by KUB, document name of LIP who checked the x-ray, date, time, and tube location (stomach or duodenum) on Physician's Order Sheet as a verbal order.			
19. Feeding should be started only after verification of placement of tube and upon order of LIP.			

The completion of this form validates the above nurse's competency for this skill.

#1 Pass / Fail Competency Validator Signature: _____

#2 Pass / Fail Competency Validator Signature: _____