Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Nasal Retention Device Policy

This procedural document supersedes: PAT/T 69 v.2– Nasal Bridle Policy.

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Executive Sponsor(s):	Abigail Trainer, Director of Nursing
Author/reviewer: (this version)	Hannah Stirland – Lead Nutrition Nurse Specialist
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Approved by:	Patient Safety Review Group
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Date issued:	April 2022
Next review date:	January 2025
Target audience:	Trust-wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 3	April 2022	• Audit removed as no longer completed • Training updated as clinical skills package now available • Wards where devices available updated	Hannah Stirland
Version 2	5 March 2019	• Title changed to nasal retention device and wording changed throughout policy. • Standard paragraph added regarding best interest decisions	Hannah Stirland
Version 1	4 January 2017	This is a new procedural document, please read in full.	Hannah Stirland

Contents

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1 INTRODUCTION

Adequate nutrition in patients is essential to promote recovery. Malnutrition is associated with increased morbidity and prolonged length of stay (NICE, 2006). Feeding tubes, including nasogastric (NG) and nasojejunal (NJ), are essential tools in delivering nutritional support. However, patients in the acute phase of their illness frequently become restless and inadvertently remove feeding tubes and other essential access lines (Williams, 2008), requiring frequent replacement. This interrupts the delivery of nutrition to the patient and submits them to repeated uncomfortable reinsertion procedures, potential exposure to x-ray, as well as significant cost implications in terms of health care practitioners' time and resources (Popovich, 1996).

NG tube placement is usually the responsibility of the registered nurse (Colagiovanni, 1999). This procedure can be an unpleasant experience for the patient, particularly if it induces retching or coughing. Safety alerts from the National Patient Safety Agency (2011, 2016) regarding the procedure for checking NG tubes, serves as a reminder that the process of placing and managing NG tubes requires considerable skill and competence in order to minimise risks to the patient. This includes minimising the number of intubations each patient has to undergo.

One of the most frequent complications of NG feeding is inadvertent tube removal (Williams, 2008). Many methods have been used for securing NG tubes, such as adhesive tapes and suturing. However, these methods are often ineffective or painful for the patient. National clinical guidelines for stroke (2012) explicitly recommend people with acute stroke who are unable to take adequate nutrition and fluids orally should be considered for tube feeding with a nasogastric tube within 24hrs of admission and considered for a nasal retention device.

2 PURPOSE

This policy covers the use of licenced nasal retention devices only

Nasal retention devices use two probes with magnets at the end to pass an umbilical tape around the vomer bone to create a loop, with a clip to secure the loop and the tube together. The aim of using a nasal retention device is to prevent inadvertent displacement or removal of naso-enteral feeding tubes by promoting safe, standardised use of a naso-enteral fixation device in patients whom its use is deemed appropriate.

The clear clinical benefit of using nasal retention devices is intended to be improved patient care through the optimal treatment with enteral feeding and administration of medication.

3 DUTIES AND RESPONSIBILITIES

Ward medical and nursing teams will be responsible for initially identifying patients who may benefit from use of a nasal retention device. This will then be discussed with the patient and/or next of kin, members of the multi-disciplinary team (MDT) which may include the managing consultant, dietitian, ward nursing staff and the nutrition nurse specialist. Following a full patient assessment the decision to insert a nasal retention device must be agreed and documented by at least two members of the MDT including the consultant whose care the patient is under.

Ward nursing teams have responsibility for arranging placement of the nasal retention device by an appropriately trained and competent practitioner; ward nursing staff will be responsible for the daily care of the retention device.

If a nasal retention device is to be considered for a patient on the Bassetlaw site, as this is likely to be very rare it must be discussed with the Nutrition Nurse Specialist (via bleep 1812) and the gastroenterology consultant at BDGH.

The nutrition nurse specialist is responsible for assessing suitable patients as part of the MDT, inserting a nasal retention device if required, monitoring of the patient when in a ward area, audit and record keeping for the use of nasal bridles throughout the trust.

DCC- The consultants will be responsible for inserting the nasal retention device in appropriate patients; the nursing team will ensure the correct aftercare is provided.

4 PROCEDURE

4.1 Indications for nasal retention device

Patients will be considered for nasal retention device insertion if:

- There is documented evidence of inadvertent displacement of the NG/NJ tube
- An enteral feeding tube is placed peri-operatively and where enteral access will no longer be available if the tube becomes misplaced or removed
- The placement of the NG/NJ tube is of high risk or technically difficult
- There is documented medical evidence for the need for essential nutrition and medication that cannot be given in any other less restrictive option.

4.2 Contraindications/considerations for nasal retention device

Nasal retention devices are contraindicated or should be given consideration in:

- Patients who have capacity and refuse treatment or where there is a valid Advanced Decision to Refuse Treatment (ADRT) in place which is specific to this situation. In these circumstances you must always seek advice from the Risk Department.
- Extremely confused/agitated patients who may continue to pull the tube and cause trauma to nasal septum
- Patients with basal skull fractures/facial fractures
- Patients with deviated nasal septum/mechanical obstruction of the nasal airway
- Patients with any structural deformity of the nose or nasopharynx
- Patients with severe blood clotting disorders, INR >1.5
- Patients who are unable to demonstrate appropriate response to painful stimuli, e.g. some head injuries, advanced dementia

Patients with dementia should be considered on an individual basis after consultation with the MDT and family. Tube feeding and nasal retention device placement should only be done in the patient's best interest.

On occasion DCC may use nasal retention devices in patients who are coagulopathic, confused/agitated or who are unable to demonstrate appropriate response to painful stimuli. This is a consultant decision where the risks may be assessed and a higher level of nursing care is available.

4.3 Consent/Best Interest Decision

The decision to use nasal retention device should be a multidisciplinary decision between the Consultant, Nurses, Dietitians, patient and relatives.

Valid consent must be obtained and documented in the patient's medical notes prior to using nasal retention device.

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.

- Further information can be found in the MCA policy, and the Code of Practice, both available on the intranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*
If the patient lacks capacity, a formal assessment of capacity must be carried out and best interest's decision made using the Trust recognised assessment tool (see PAT/PA 19 Mental capacity act, 2005), a copy of which must be kept in the patient's medical notes. There must be a discussion and full involvement of the next of kin/family/carers prior to use.
If the patient is on DCC the decision to insert a nasal retention device will be done so in the patient's best interest and will be made by the consultant intensivist.

4.4 Process

Wards

- Patient must have clearly documented evidence of need for naso-enteral feeding tube and nasal retention device. Discussion should take place with the medical team including the managing consultant
- A Mental Capacity Assessment must take place that is decision specific and time specific
- Patient consent must be sought where appropriate
- If the patient lacks capacity then a Best Interest meeting/discussion involving MDT and next of kin/family to take place. Complete trust record of best interest decision and file in medical notes, these should include both MCA 1 and MCA2 forms (see PAT/PA 19)
- Only when there is clear evidence that all the above steps and consultant agreement have been completed can nasal retention device be used
- Acute stroke unit (ward 16), gastroenterology (ward 24), ENT surgery, respiratory wards and DCC at Doncaster Royal Infirmary and ICU at Bassetlaw will store the nasal retention devices. When issued to another ward the nutrition nurse specialist must be informed and that ward will be required to order equipment which will then replace that taken from the stock.

DCC

- Patient must have clearly documented evidence of need for naso-enteral feeding tube and nasal retention device
- Decision will be made by the intensivist in the patients best interest and documented accordingly

All Areas

- Nasal retention devices should be placed by a competent and fully trained member of staff from one of the above areas or the nutrition nurse specialist
- Ward staff must instigate nasogastric/nasojejunal care plan immediately on commencing use of any naso-enteral tube and retention device
- Any serious untoward incidents whilst using the nasal retention device should be escalated immediately, a Datix report must be completed and nutrition nurse specialist informed
- If at any point the patient becomes distressed and is clearly showing signs of refusal of naso-enteral tube/retention device then the intensivist/MDT and next of kin/family must review the best interest decision
- In such circumstances it is advisable to seek advice from the safeguarding team about the potential for application for Deprivation of Liberty Safeguards (DOLS)

PATIENTS LACKING CAPACITY

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- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
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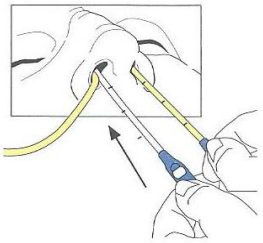
Quick Placement Tips

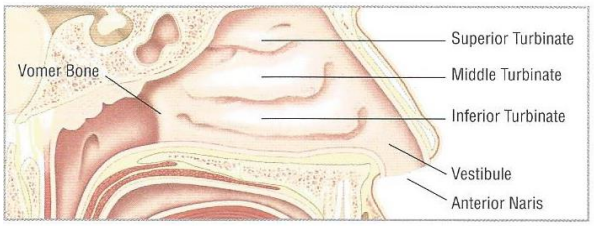
Quick Placement Tips

1 Insertion Tips

A. Move the feeding tube to the outside and place the catheter between the septum and the tube.

B. When inserting catheters, stay below the inferior turbinate at the base of the nostril and aim straight back/parallel to each other to connect magnets as soon as catheter tips pass the angle of the vomer bone.





C. If connection is not immediately made, widen the catheters into a "V" shape to assist in making the connection.

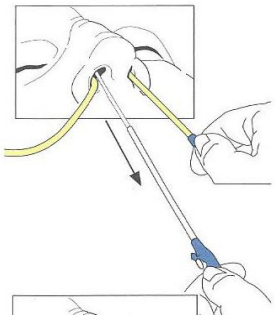
2 Magnet Connection Tips

A. **Tactile:** After both catheters have been inserted, the connection can be felt when the magnets connect.

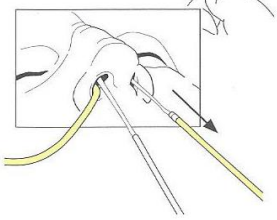
B. **Visual:** If the tactile connection cannot be felt, observe for a visual connection by applying a very gentle push and pull motion with the YELLOW Catheter while observing for parallel movement of the WHITE Catheter to validate the magnets have connected.

3 Withdrawing the Catheters

A. **IMPORTANT!** Hold the YELLOW Catheter in position, then slowly withdraw JUST the WHITE Catheter about 10 cm out of the nostril.



B. THEN slowly withdraw the YELLOW Catheter to pull the umbilical tape behind the vomer bone and out the other nostril.



Lubrication Tips

1. When applying lubricant to Catheters, avoid magnet ends.
2. Do not apply lubricating jelly to umbilical tape, as this will increase drag. Consider moistening the umbilical tape with water or saline prior to insertion.

Nasal retention devices are tube size specific, ensure correct size is used

Procedure may vary slightly according to manufacturer, please ensure correct training has been undertaken prior to inserting a nasal retention device.

The Corgrip nasal retention device should be changed every 30 days.

5 TRAINING/SUPPORT

Training for insertion of nasal retention devices should be limited to practitioners working within areas of high usage to gain competence and experience, including DCC (Department of Critical Care) the Stroke Unit, gastroenterology ward and the Nutrition Nurse Specialist.

A small number of nurses from Acute Stroke Unit, gastroenterology ward and the Nutrition Nurse Specialist will be trained to insert the nasal retention device. Initial and ongoing training in the form of a clinical skills package will be provided by the nutrition nurse

specialist. Practitioners wishing to obtain this skill must ensure they remain competent and seek further training when required. Training will be registered on OLM after completion of the clinical skills package and renewed 3 yearly.

Daily care of the nasal retention device will be the responsibility of the nurse caring for the patient, therefore training in high use areas will be provided by the nutrition nurse specialist or company representative. If on the odd occasion a retention device was to be used in an area where training had not taken place, a risk assessment would be carried out and training would be provided at the time to that area.

Support will be available from the nutrition nurse specialist and stroke consultants on the use of nasal retention devices.

Please note: The training requirements of staff will be identified through a learning needs analysis (LNA). Role specific education will be co-ordinated/ delivered by the topic lead. Alternatively, training may be accessed via an approved e-learning platform where available.

6 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Adverse incidents relating to the use of the nasal retention device	Ward areas/departments to complete Datix	When required	Nutrition Steering Committee
Training and ongoing competence	Ward managers	Annually	At PDA and via clinical skills package recorded on ESR

7 DEFINITIONS

DCC – Department of critical care
ICU – Intensive care unit
MDT – Multidisciplinary team
NG - Nasogastric
NJ – Nasojejunal

8 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment for All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. **(See Appendix 1)**

9 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Mental Capacity Act 2005 – Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) – PAT/PA 19
Privacy and Dignity Policy – PAT/PA 28
Fair Treatment for All Policy – CORP/EMP 4
Equality Analysis Policy – CORP/EMP 27

10 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

11 REFERENCES

Colagiovanni, Lynne (1999) Taking TheTube, Nursing Times, Vol 95, No21 63-68.

National Clinical Guidelines for stroke fourth edition (2012) Royal College of Physicians

National Patient Safety Alert (2016) Nasogastric tube misplacement: continuing risk of death and severe harm.

National Patient Safety Alert (2005) & (2011) Reducing harm caused by the misplacement of nasogastric feeding tubes in Adults, Children and Infants.

NICE (2006). Clinical Guideline 32 Nutrition Support in Adults, February 2006

Popovich, M.J., Lockrem, J.D., Zivot, J.B. (1996). Nasal bridle revisited: an improvement in the technique to prevent unintentional removal of small bore nasoenteric feeding tubes. Critical Care Medicine. 24(3) p429-31

Williams, J (2008) Exploring ethically sensitive decision-making in acute hospital care: using hand control mittens in adult patients. In Shaw, T and Sanders, K (Eds) Foundation of Nursing Studies Dissemination Series. Vol. 4. No. 8.

Department of Constitutional Affairs Mental Capacity Act (2005): Code of Practice, 2007 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

APPENDIX 1 – EQUALITY IMPACT ASSESSMENT PART 1 INNITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Nasal Retention Device Policy	Trust Wide	Hannah Stirland	Existing	4/3/22

1) Who is responsible for this policy? Name of Division/Directorate:

2) Describe the purpose of the service / function / policy / project/ strategy? Intended to benefit patients requiring NG feeding

3) Are there any associated objectives? No

4) What factors contribute or detract from achieving intended outcomes? – Not applicable

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: **January 2025**

Checked by: **Jessica Thomson** **Date:** **8/3/22**