synchronize passing the tube with swallowing.

Confirm placement (see Translating Evidence into Practice box).

Stabilize the tube by holding or taping it to the cheek, not to the forehead, because of possible damage to the nostril. To maintain correct placement, measure and record the amount of tubing extending from the nose or mouth to the distal port when the tube is first positioned. Recheck this measurement before each feeding.

Warm the formula to room temperature. Do not microwave! Pour formula into the barrel of the syringe attached to the feeding tube. To start the flow, give a gentle push with the plunger but then remove the plunger and allow the fluid to flow into the stomach by gravity. The rate of flow should not exceed 5 ml every 5 to 10 minutes in premature and very small infants and 10 ml/min in older infants and children to prevent nausea and regurgitation. The rate is determined by the diameter of the tubing and the height of the reservoir containing the feeding and is regulated by adjusting the height of the syringe. A usual feeding may take 15 to 30 minutes to complete.

Flush the tube with sterile water (1 or 2 ml for small tubes to 5 to 15 ml or more for large ones), or see discussion of flushing for administering medication through nasogastric (NG) tubes in the Nursing Care Guidelines box in this chapter to clear it of formula.

Cap or clamp indwelling tubes to prevent loss of feeding.

- If the tube is to be removed, first pinch it firmly to prevent escape of fluid as the tube is withdrawn. Withdraw the tube quickly.

Position the child with the head elevated 30 to 45 degrees or on the right side for 30 to 60 minutes in the same manner as after any infant feeding to minimize the possibility of regurgitation and aspiration. If the child's condition permits, burp the youngster after the feeding.