

Record the feeding, including the type and amount of residual, the type and amount of formula, and how it was tolerated.

- For most infant feedings, any amount of residual fluid aspirated from the stomach is refeed to prevent electrolyte imbalance, and the amount is subtracted from the prescribed amount of feeding. For example, if the infant is to receive 30 ml and 10 ml is aspirated from the stomach before the feeding, the 10 ml of aspirated stomach contents is refeed along with 20 ml of feeding. Another method can be used in children. If residual fluid is more than one fourth of the last feeding, return the aspirate and recheck in 30 to 60 minutes. When residual fluid is less than one fourth of the last feeding, give the scheduled feeding. If large amounts of aspirated fluid persist and the child is due for another feeding, notify the practitioner.

Studies evaluating NG and OG tube length in infants and children found that age-specific methods for predicting the distance based on height is a more accurate estimate of internal distance to the stomach ([Beckstrand, Ellett, and McDaniel, 2007](#); [Klasner, Luke, and Scalzo, 2002](#)). The morphologic measure most commonly used by clinicians, nose–ear–xiphoid distance, is often too short to locate the entire tube pore span in the stomach. However, the nose–ear–midxiphoid umbilicus span approached the accuracy of the age-specific prediction equations and is easier to use in a clinical setting. The best option is to adapt the nose–ear–midxiphoid umbilicus measurement for NG or OG tube length ([Fig. 20-20, A](#)) (see Nursing Care Guidelines box).