Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Percutaneous Endoscopic Gastrostomy (PEG)/Enteral Tube Care Policy

This procedural document supersedes: PAT/T 16 v.3 – Percutaneous Endoscopic Gastrostomy (PEG) Management.

Did you print this document yourself?
The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Author/reviewer: (this version)	Rebecca Wilkey - Ward Manager S12, Janet Ryles - McMillian Nurse Head & Neck, Debi Oxley - Sister Endoscopy, Mary Peck - Senior Dietitian
Date revised:	January 2015
Approved by:	Policy Approval and Compliance Group
Date of approval:	31 March 2015
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Next review date:	March 2016
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 4	1 April 2015	• Title change • Covers the full patient pathway from assessment to discharge, including management in the community • Omit Peri-skin PEG Skin Care Policy • Indications for feeding tube updated • MDT responsibilities included • Removed reference to PEG nurse • PEG IPOC WPR numbers included • Associated Trust procedural documents identified • Appendix updated • Contact details updated • References updated	Rebecca Wilkey, Ward Manager S12 Debi Oxley, Senior Sister/ Endoscopy Lead Janet Ryles, McMillan Nurse Head & Neck Mary Peck, Senior Dietitian
Version 3	February 2011	• Title change • Policy combined with the PERI Peg Skin Policy - PAT/T 10 v.3 • Format changed throughout • Guidelines removed from the policy pending implementation of PEG IPOC • Changes of care within IPOC to include: • Patients start feeds at 4 hours, • Clean area with normal saline first 48 hours • Contact details changed with the employment of the PEG Nurse • References updated • Appendix updated and re-designed	Ann Clemitshaw - PEG Nurse Specialist
Version 2	September 2007	• Changed from checking bowel sounds to initiate first feed to checking PH level • If at any time patient complains of pain or if there is any redness or swelling stop the feed added • Wording changed throughout to catheter tip syringes	Ann Clemitshaw - Sister, Endoscopy Debi Oxley – Senior Sister, Endoscopy Carol Bryant - Sister, Endoscopy Vera Todorovic - Consultant Dietitian DR J Sayer -Consultant Gastroenterologist DR R Bolton - Clinical Director, Consultant Gastroenterologist

Contents

Associated documentation:

- PEG/Enteral Tube Referral and Placement Pathway **WPR35452**
- Day of insertion to Day 27 **WPR35461**
- Continuous Care of PEG Day 28 onwards **WPR35391**
- Low Profile Feeding Device Button **WPR35441**
- Balloon Gastrostomy Tube **WPR35411**
- Feeding Jejunostomy Tube Care – Day 1-14 **WPR35431**
- Radiologically Inserted Gastrostomy Tube (RIG) **WPR35421**
- Discharge Care Pathway **WPR35481**
- Enteral Nutrition Regimen **WPR19041**
- Bolus feeding Regimen **WPR28660**
- Out of Hours Enteral Feeding Regimen for Adults **WPR28610**

Policy: PAT/T 35 - A Practical Guide to Nutrition Support for Adult

1. INTRODUCTION

The aim of this policy is to ensure that all patients receive a high standard of evidence-based practice throughout the Trust before, during and following the placement of an enteral feeding tube this policy excludes naso-gastric and naso-jejunal tubes.

Health professionals must be aware of the type of enteral feeding tube that their patient has in place to ensure that the correct procedures are followed.

The following tubes are useful well-established forms of delivering enteral feed to patients who will require nutrition for a period of one month or more:

- A Percutaneous Endoscopic Gastrostomy (PEG) is a feeding tube which passes through the abdominal wall directly into the stomach. These tubes are designed to stay for a long time.

- A Percutaneous Endoscopic Jejenostomy is a tube that is passed through the PEG tube into the jejenum. This extension tube is narrow and therefore may block easily. If this happens the tube will need to be changed.

- A Low-Profile Feeding Device (LPFD) or Button is a feeding tube which passes through the abdominal wall directly into the stomach which is held in place with a water filled balloon. These devices need changing every 4 months.

- A Balloon Gastrostomy Tube (GT) is a feeding tube which passes through the abdominal wall directly into the stomach and is held in place with a water filled balloon. These tubes need changing every 3 months.

- A Jejunostomy is a feeding tube inserted through the abdominal wall into the jejunum. These are secured in place in theatre with internal and external sutures.

- A Radiologically Inserted Gastrostomy (RIG) is a feeding tube inserted through the skin directly into the stomach under x-ray screening. These are normally removed after 3 months and replaced with an alternative feeding tube e.g. LPFD or GT.

- The Low-Profile Transgastric-Jejunal Feeding Tube is a single unit feeding tube. It enters the stomach through a gastric stoma. The tube is held in place (within the stoma tract) by means of a water filled balloon. These are changed every 3 months.

The decision to initiate long term feeding will involve the patient, carer/family, and members of the multi-disciplinary team including Speech and Language Therapists and Dietitians. The clinical indications for enteral feeding must be reviewed regularly to prevent unnecessary device use.

2. PURPOSE OF POLICY

This policy has been developed to promote the safety of the patient and to unify the processes involved in enteral feeding referral, management and skin care of feeding sites. This will ensure that health workers throughout the Trust are delivering standardised care and management of patients requiring feeding via the aforementioned tubes.

3. DUTIES AND RESPONSIBILITIES

3.1 Responsibilities

The Director of Nursing and Governance is responsible for the development and monitoring of the policy implementation and assurance systems.

All clinical service team managers are responsible for ensuring compliance with the policy within their unit/team and that staff are competent in the practice of long term tube management and attend appropriate training.

All Trust employees involved in the practice of enteral feeding are responsible for ensuring they are competent in the procedures used and deliver practice to the policy standards.

Certain professional groups have specific responsibilities:

Dietitians are responsible for:

- Assessment and monitoring the patient's nutritional status.
- Advising on the appropriateness for enteral feeding.
- Advising on a suitable feeding regime to meet the patient's nutritional requirements.
- Monitoring the nutritional status of a patient on enteral feeding and tolerance to the feeding regime and advise of any necessary changes.
- Arrange training by the Nutricia nurse for the patient prior to discharge.
- Registering patients on Homeward for the supply of equipment/feed on discharge.

Speech and Language Therapists are responsible for:

- Assessment of patients eating and drinking skills and any difficulties (dysphagia)
- Provision of advice on the appropriateness of enteral feeding with regards to dysphagia
- Monitoring dysphagia while the patient is on an enteral feeding regime, where necessary providing information for the MDT with regard to reinstatement of oral feeding
- Assessment and provide advice on oral intake/tasters for patients who are enterally fed long term.

Pharmacy is responsible for:

- Providing a medicine information service for staff, patients and carers and advising on medicine administration in patients unable to take medicines orally
- Advising on and monitoring the safe, effective and economic use of medicines

- Monitoring for medicine interactions/adverse reactions and whether the therapy is achieving the desired therapeutic end points
- Reviewing and advising on changes according to New Edinburgh Guidelines
- Monitoring appropriate medications that are prescribed are suitable to be given via a feeding tube

Medical/clinical staff are responsible for:

- Monitoring of bloods, urea and electrolytes and correcting any imbalances.
- Treatment of micronutrient and biochemical deficiencies through supplements.
- Management (insertion and on-going care) of feeding devices e.g. PEG feeding tubes.
- Management, recognition and treatment of complications relating to feeding.
- Management, recognition of the manufactures guidelines for individual tube type care
- Ensuring that the enteral (purple) 60ml syringe is used for plunging medication and flushes only, not feed
- Ensuring the correct IPOC is used from referral to discharge:
    - PEG/Enteral Tube Referral and Placement Pathway WPR35452
    - Day of insertion to Day 27 WPR35461
    - Continuous Care of PEG Day 28 onwards WPR35391
    - Low Profile Feeding Device Button WPR35440
    - Balloon Gastrostomy Tube WPR35410
    - Feeding Jejunostomy Tube Care – Day 1-14 WPR
    - Radiologically Inserted Gastrostomy Tube (RIG) WPR35420
    - Discharge Care Pathway WPR35480

The Nutricia Nursing Service:

- Nutricia Nurses will teach patients and carers on aspects of home enteral feeding to meet their individual requirements.
- The Nutricia Nurses will keep updated of current best practice guidelines.
- The Clinical Governance/Practice Leads will ensure policies are reviewed annually to reflect any changes
- The Nutricia Nurses will work in partnership with other healthcare professionals to share information and expertise thus providing an integrated approach to patient care

The Nutricia Nurses will be guided by and adhere to the standards of conduct, performance and ethics for nurses and midwives as directed by the Nursing and Midwifery Council (2008). Nutricia have their own Training Policies and Procedures, which is available for reference from Nutricia Limited. See **Appendix 4** for Nutricia contact details.

3.2 Ethical and Legal Considerations

Nutritional support is not always appropriate. Decisions on withholding or withdrawing nutrition support require a consideration of both ethical and legal principles, both at common law and statute including the Human Rights Act 1998.

When such decisions are being made guidance issued by the General Medical Council (GMC) and the Department of Health should be followed. The decision making process and rationale must be fully documented in the clinical record.

Patients have the right to refuse treatment for various reasons. Refer to the Trust Policy PAT/PA 19 - Mental Capacity Act 2005 Policy and Guidance and PAT/EC 1 - Resuscitation Policy.

When such decisions are being made guidance issued by the General Medical Council (GMC) and the Department of health should be followed. The decision making process and rationale must be fully documented in the clinical record.

3.3 Consent

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare. Refer to Trust Policy PAT/PA 2 – Policy for Consent to Examination or Treatment

Prior to referring any patient for PEG/enteral tube placement please refer to Trust guidance on the Mental Capacity Act, and to be aware of any patient with an Advance Decision to Refuse Treatment (ARDT).

3.4 Mental Health Capacity Act

The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who may not have the capacity to make their own decisions about specific treatments and/or care. Refer to the Trust Policy PAT/PA 19 – Mental Capacity Act 2005 Policy and Guidance.

3.5 Record Keeping and Documentation

Clear documentation in the patient's notes is required regarding the reason for placement of long term feeding tube.

The insertion of enteral tubes and any further or subsequent information (e.g. tube changes) must be documented in the clinical records and IPOC (Integrated Pathway of Care).

All feeds must be prescribed on the feeding regime by the Dietitian. **Appendix 1** pump - WPR 19041, **Appendix 2** bolus WPR 28660.

Patients awaiting dietetic assessment can be commenced on the out of hours feeding regimen. **Appendix 3** WPR 28610.

Administration of feeds must be signed, on the reverse side of the feeding regimen documentation, by the nurse undertaking the feed. (**Appendix 1**).

3.6 Infection Prevention and Control

There are potential hazards associated with enteral feeding which can make it a source for the growth of micro-organisms. Liquid nutrients provide an ideal medium for bacteria and can cause cross contamination to the feeding system during setting up and handling the equipment. Refer to the Trust Policy PAT/IC 19 - Standard Infection Prevention and Control Precautions Policy.

- Decontaminate hands thoroughly using soap and water or alcohol hand gel before and after handling equipment and the preparation process.
- Prepare equipment and opening of feed in a clean environment.
- A no-touch technique should be adopted when preparing the feed during priming and connecting to the administration set/feeding tube.
- Commercially produced, pre-filled ready to hang feeds must be used wherever possible as these are least likely to become contaminated in preparation and use.

3.7 Storage and Care of Feed

All feed packs should be stored in a cool dry place at room temperature, away from direct sunlight. Once opened bottles of feed for bolus feeding should be stored in a refrigerator and any unused feeds should be discarded after 24 hours. All feeds should be administered at room temperature.

4. INDICATIONS AND REFERRAL

4.1 Indications for Feeding Tube

Feeding tubes are used in adults who are unable to swallow or unable to eat enough and need long term artificial feeding. In some cases PEGs/enteral tubes are used to give extra nutrition (or supplements) to people who can still eat.

Feeding tubes may be considered in the following:

- An event which impairs the client's ability to swallow and protect the airway (those at risk of aspiration)
- Dysphagia – assessed by the speech and language therapist
- Loss of appetite that results in significant weight loss
- Diseases of the digestive system
- Increased nutrition needs that cannot be met by eating and drinking alone.
- Anorexia
- Semi consciousness
- Unintentional weight loss greater than 10% within the previous 3 months
- Nasal gastric tube in place for long term feeding
- Head & Neck Surgery
- Neurological conditions

4.2 Referral for PEG

The multi-disciplinary team should discuss with medical staff the indication for enteral feeding via a PEG tube; this should be documented by medical staff in the patient/clients records.

All PEG referrals must be made on the Trust PEG/Enteral Tube Referral and Placement Pathway WPR35452.

The Speech and Language Therapy (SALT) - Section 2 may be completed by the referring team from the advice/assessment and recommendations documented by SALT in the patient's case notes.

The Endoscopy Nurse will inform the patient/ward of the planned date.

All out-patients require admission to the ward post procedure.

All patients must have a Meticillin Resistant Staphylococcus Aureus (MRSA) screen prior to placement.

Early referral to the dietitian is paramount so that a suitable feeding regime can devised if necessary. Patients having tubes placed pre-chemo/radiotherapy may not need feeding regimes on placement. The endoscopy team are to fax a referral to the dietitians on receipt of IPOC.

4.3 Referral for RIG

Patients that have a failed PEG placement or are unable to open their mouth sufficiently to endoscope may be suitable for a RIG. These patients are referred to x-ray for RIG placement.

X-ray staff are to inform Dietitians and the endoscopy unit that a RIG has been placed to ensure correct procedures and follow-up are arranged.

5. INSERTION AND PROCEDURES

5.1 Procedure for PEG placement

A PEG is inserted in a number of ways but the simplest involves an examination of the stomach with an endoscope passed through the mouth. A PEG feeding tube is then passed into the stomach through a small opening on the wall of the abdomen. Attached to the tube there is a small plastic disc which lies close to the skin to prevent movement of the tube and a small clamp or plastic cap which keeps the tube closed when feeding is not taking place. This requires a minor procedure and is usually done after a sedative injection although some people will require a short general anaesthetic. JEJ, RIG and Transgastric-Jejunal Feeding will require a surgical procedure.

GT tubes and LPFD devices can be inserted once the PEG site has fully formed, these patients should be referred to endoscopy for the first placement.

All IPOC's for the care post procedure are as listed previously.

5.2 Care of the long term feeding site

For newly sited feeding tubes follow the IPOCs regarding cleaning and observations. The Nutricia nurse will train the patient/carer prior to discharge from hospital and provide support post discharge.

Gastrostomy exit sites should be cleaned daily as per IPOC. Observe the site for tenderness, irritation, redness or pressure and for the presence of any discharge or leakage. Unless there is a large amount of gastric leakage the site should be left uncovered.

5.3 Early Detection of Complications Post Tube Insertion

All staff need to be aware of the following warning signs that need **urgent** attention:

- Pain on feeding
- Prolonged or severe pain post procedure
- Fresh bleeding
- External leakage of gastric contents.

STOP feed or medication immediately and urgently refer to the team that performed the gastrostomy insertion.

If an established PEG tube falls out or is accidentally pulled out a replacement tube needs to be inserted straight away. This does not apply to a newly placed PEG.

A new tube needs to be inserted as soon as possible as the stoma will start to heal within 2 to 24 hours and/or completely close soon after the tube has come out.

If you have not been trained DO NOT attempt to place a new tube in the stoma.

- Remain calm
- Place a clean gauze dressing over the stoma to prevent stomach contents leaking onto the skin or clothes
- Inform the on call doctor to escalate to the correct surgical team or endoscopy department

5.4 Checking the Position of Feeding Tube

On all new or changed feeding tubes checking the measurement is essential to ensure the tube is still in the correct position. Should the feeding tube become dislodged this can potentially lead to life threatening complications.

The following complications can occur post procedure:

- Gastric outlet obstruction.
- Buried bumper syndrome (migration of the internal bumper of the PEG tube into the gastric or abdominal wall).
- Dislodged PEG tube.
- Peritonitis.
- Peristomal leakage or infection.
- Skin or gastric ulceration.
- Blocked PEG tube.
- Tube degradation.
- Gastric fistula after removal of the PEG tube.
- Granulation around site of insertion of the PEG tube.

On insertion of the PEG tube, the measurement will be recorded on the IPOC. It is vital this is checked every shift and follow IPOC guidelines. PEGS do not require PH testing.

5.5 Checking the Position of Low Profile Feeding Device and Balloon Gastrostomy Tubes by pH Measurement

It is essential that the pH is checked before and after water change.

Procedure

- Wash hands
- Remove end cap from the gastrostomy tube (ensure the clamp is closed) attach a 50ml syringe to the tube (open the clamp)
- Very slowly and carefully pull back on the plunger of the syringe until a small amount of fluid (at least 0.5 – 1ml) appears in the syringe
- Close clamp and replace cap
- Place a little fluid on the pH indicator paper
- If the pH value is 5.5 or less the tube is in the correct position
- If the pH value is more than 5.5 do not administer anything via the tube.

Check the pH again in 30 – 60 minutes if the pH remains above 5.5 contact medical staff

5.6 Management of Tube Feeding

5.6.1 Method of feeding

Feeds can be administered through the use of an electronic feeding pump or using a syringe for bolus feeding. Choosing the right method of feeding is important to maximise tolerance for each individual client.

The two basic methods are:

5.6.2 Pump feeding for continuous feeding

The use of a pump allows close control of the rate of delivery of the formula.

- It can be delivered continuously, just overnight or just during the day depending on what suits the patient.
- For those that have an oral intake in conjunction with PEG feeding, it is often useful to use pump feeding overnight to allow them time off PEG feeding and encourage oral intake during the day.
- By slowing the rate of delivery we can improve tolerance for people that may have delayed gastric emptying, reflux and nausea or vomiting. In turn this can reduce aspiration risk.
- Most feeds come in a ready-to-hang pack that connects easily to a feeding pump. This makes it an easy unit for feed administration.

5.6.3 Bolus feeding

- Bolus feeding using a syringe is the most common feeding method used. Bolus feeds usually consist of the prescribed feed for one sitting given via a syringe.
- Ideally the syringe should just be held with the plunger removed, allowing gravity to send through the feed.
- However, sometimes a small amount of pressure is needed on the plunger to direct thicker feed in.
- The bolus method provides the client with their requirement of calories daily.
- For most people bolus feeding is the preferred option, however if there are any signs of intolerance e.g. diarrhoea and/or vomiting, then another method of feeding should be sought.

For further advice on feed/drug administration, refer to the following policy - A Practical Guide to Nutrition Support for Adults.

5.7 Discharge

For discharge of all feeding tube patients the Discharge Care Pathway IPOC should be followed.

The patient must be informed that if the feeding tube falls out they follow **Appendix 4**.

The Nutricia nurse will come into the wards Monday-Friday to provide teaching and support to the patient/carer. Should the patient be discharged on a weekend, ward staff will need to train the patient and Nutricia nurse will visit in the week.

All discharge referrals to Nutricia will be made by the dietitian.

The dietitian will require 48 hours' notice of discharge to order the feeds required and any equipment needed.

The patient/carer or district nurse will need 10 days of equipment (out of area patients require 14 days

- 60ml oral/enteral syringe
- Sterile Water for flushing
- Feed
- Extension tube appropriate for the type of tube
- Feed giving sets (if patient on pump feed)

If the patient is on a continuous feed they will need to be discharged with a Flocare Infinity Pump, this will be supplied by the dietitian.

6. TRAINING/ SUPPORT

Health professionals must be able to evidence an on-going competence and management in the care of these patients through annual training and updates. All training is document on OLM.

The Nutricia nurse will attend the Trust and provide on the ward training to all staff.

7. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Each ward area's clinical manager will manage the competence of their own staff, ensuring this policy is adhered to. Any incident connected with non-compliancy of this will be reported on DATIX. Ward managers analyse this data as part of their monthly data and review to inform their Speciality Care Group Governance meeting.

8. DEFINITIONS

Aspiration	food or fluid entering of the lungs.
Bolus feed	measured amount of feed and water given by syringe via PEG tube over 15 – 20 minutes.
Continuous feeding	via the PEG over night or throughout the day using a pump.
Feed	liquid nutrition administered by feeding tubes.
Giving set	tubing used for pump feeding that connects the pump to the feeding tube.

Granulation tissue	pinkish red, slightly raised ring of newly growing healthy skin around the stoma.
Pump	the machine that allows the feed to be pumped through the tube at a set rate.
Reflux	the movement of stomach contents up the oesophagus [food pipe].
Stoma	the opening in the abdomen to the stomach which the feeding tube goes through.

9. EQUALITY IMPACT ASSESSMENT

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 5.**

10. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Standard Infection Prevention and Control Precautions Policy – PAT/IC 19
Mental Capacity Act 2005 Policy and Procedure - PAT/PA 19
Privacy and Dignity Policy - PAT/PA 28
A Practical Guide to Nutrition Support for Adults – PAT/T 35
Consent to Examination or Treatment Policy – PAT/PA 2
Nutricia Booklets – patient information

11. REFERENCES

British Society of Gastroenterology (2006) Complications associated with the placement of percutaneous endoscopic gastrostomy, Dr Paul O'Toole.

British Society of Gastroenterology (2011). The provision of a percutaneously placed enteral tube feeding service.

Department of Health (2011) Clean safe care: high impact intervention enteral feeding care bundle.

Human Rights Act 1998

MHRA Medical Devices Alert (2010) Medical devices in general and nonmedical products revised 2010.

Merck Pharmaceuticals (2009) The Corflo PEG feeding tube information booklet for patients and carers www.merckserono.com/ May 2011.

NMC code, The Code, Standards of Conduct, Performance and Ethics May 2008.

National Institute for Health and Clinical Excellence (2006), Nutritional support in adults.

National Patient Safety Agency (2010) Rapid response report.

NPSA/2010/RRR010 Early detection of complications after gastrostomy.

Royal College of Physicians (2010). Oral feeding difficulties and dilemmas. A guide to practical care.

APPENDIX 1 – ENTERAL NUTRITION REGIMEN

HMR 111

AFFIX LABEL HERE IF AVAILABLE

Unit Number: .....

Surname: .....

Forename(s): .....

Address: .....

.....

D.o.B.: .....

Doncaster and Bassetlaw Hospitals NHS

NHS Foundation Trust

ENTERAL NUTRITION REGIMEN: *Use in conjunction with Enteral Nutrition Prescription Form (overleaf)*

Ward: .....

Weight: .....

Height: .....

BMI: .....

Feeding Route: .....

	Estimated requirements	Full regimen provides
Energy (Kcal)	.....	.....
Protein (g)	.....	.....
CHO (g)	.....	.....
Sodium (mmol)	.....	.....
Potassium (mmol)	.....	.....
Fluid (ml)	.....	.....

Checklist:

- If naso gastric tube (NGT), check correct positioning of tube with pH paper before commencing feed
- Check safe positioning of patient (head and shoulders elevated to at least 45° angle)
- Change giving set every 24 hours
- Discard any unused feed after 24 hours
- Flush tube before and after each bottle/feed with ..... sterile water, and before and after administration of any medication

Initial Regimen (to be used on commencing feed) ***N.B. Do not pass a tube or begin feeding without doctor's consent***

Date	Feed type	Volume of feed (ml)	Rate (ml/hr)	Duration of feed (hrs)	Additional Information:

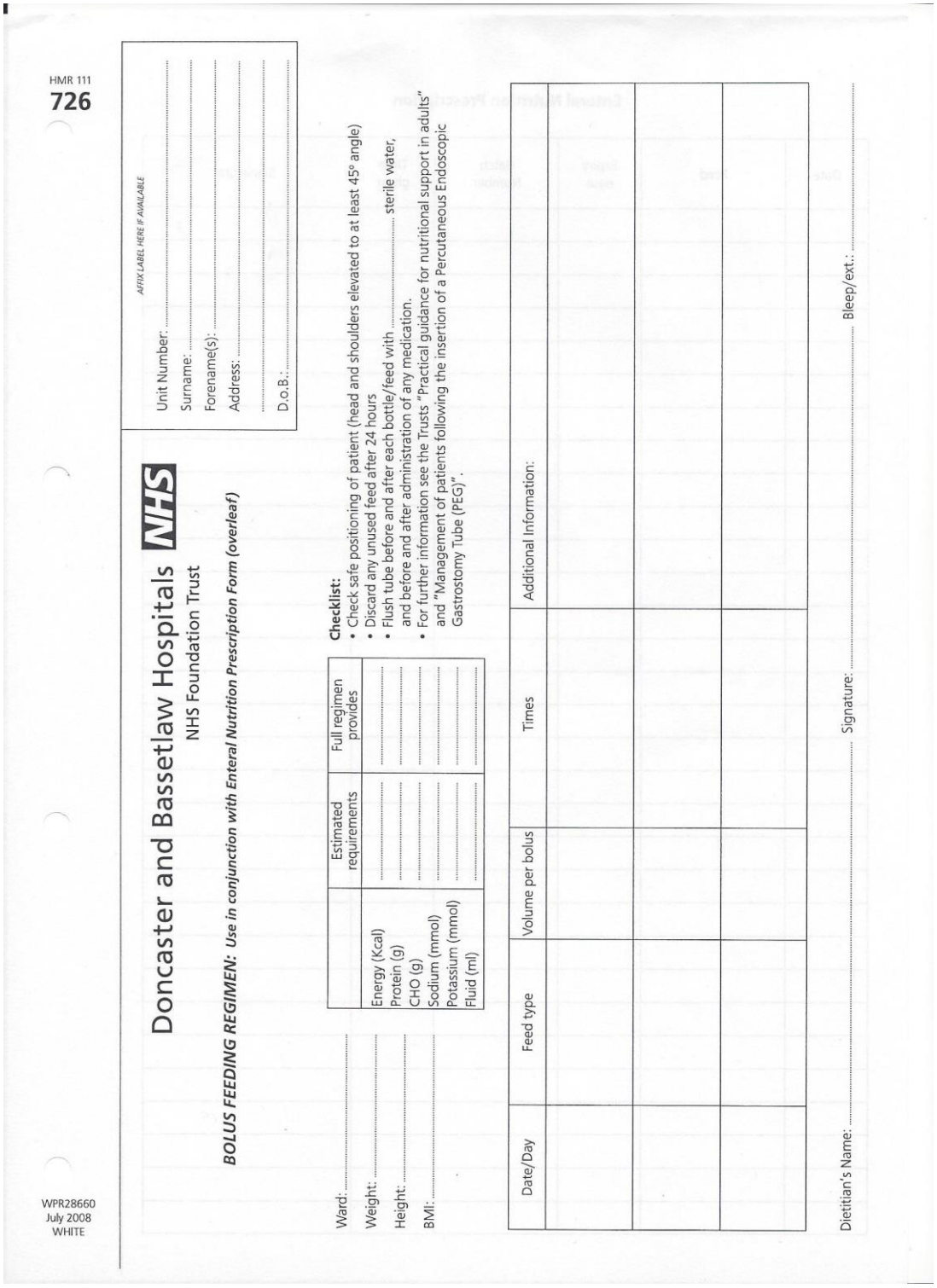
Full Regimen

Date	Feed type	Volume of feed (ml)	Rate (ml/hr)	Duration of feed (hrs)	Additional Information:

Dietitian's Name: ..... Signature: ..... Bleep/ext.: .....

WPR19041
July 2008
WHITE

APPENDIX 2 – BOLUS FEEDING REGIMEN



HMR 111
726

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

***BOLUS FEEDING REGIMEN:** Use in conjunction with Enteral Nutrition Prescription Form (overleaf)*

AFFIX LABEL HERE IF AVAILABLE

Unit Number: .....
Surname: .....
Forename(s): .....
Address: .....
.....
D.o.B.: .....

Ward: .....
Weight: .....
Height: .....
BMI: .....

	Estimated requirements	Full regimen provides
Energy (Kcal)	.....	.....
Protein (g)	.....	.....
CHO (g)	.....	.....
Sodium (mmol)	.....	.....
Potassium (mmol)	.....	.....
Fluid (ml)	.....	.....

Checklist:
- Check safe positioning of patient (head and shoulders elevated to at least 45° angle)
- Discard any unused feed after 24 hours
- Flush tube before and after each bottle/feed with ..... sterile water, and before and after administration of any medication.
- For further information see the Trusts "Practical guidance for nutritional support in adults" and "Management of patients following the insertion of a Percutaneous Endoscopic Gastrostomy Tube (PEG)".

Date/Day	Feed type	Volume per bolus	Times	Additional Information:

Dietitian's Name: ..... Signature: ..... Bleep/ext.: .....

WPR28660
July 2008
WHITE

APPENDIX 3 – OUT OF HOURS ENTERAL FEEDING REGIMEN FOR ADULTS

HMR 111

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

AFFIX LABEL HERE IF AVAILABLE

Unit Number: .....
Surname: .....
Forename(s): .....
Address: .....
.....
D.o.B.: .....

OUT OF HOURS ENTERAL FEEDING REGIMEN FOR ADULTS:

Use in conjunction with Enteral Feed Prescription Form (overleaf). This regime is to be used when the dietitian is not available

Ward: .....
Weight: .....
Height: .....
BMI: .....

Checklist:

- **If naso gastric tube (NGT), check correct positioning of tube with pH paper before commencing feed**
- **Check safe positioning of patient (head and shoulders elevated to at least 45° angle)**
- **Change giving set every 24 hours**
- **Discard any unused feed after 24 hours**
- **Flush tube before and after each bottle/feed with 30mls sterile water, and before and after administration of any medication**
- **For use with NGT/PEG only**
- **For further information see the Trusts "Practical guidance for nutritional support in adults"**

N.B. Do not pass a tube or begin feeding without doctor's consent

Day	Feed type	Volume of feed (ml)	Rate (ml/hr)	Duration of feed (hrs)	Additional Information:
One	**Nutrison Multifibre**	**500mls**	**25mls**	**20hrs**	**4hrs rest**
Two	**Nutrison Multifibre**	**1000mls**	**50mls**	**20hrs**	**4hrs rest**
Three	**Nutrison Multifibre**	**1000mls**	**50mls**	**20hrs**	**4hrs rest**

- **Additional fluid may be required. Please discuss with medical team for appropriate volume.**
- **Please ensure that a signed written referral is sent to the dietitian (using current protocol).**
- **Please maintain feed at day three (if tolerated) until dietetic assessment.**

Dr/RN Name: ..... Signature: ..... Bleep/ext.: .....

WPR28610
Aug 2008
WHITE

APPENDIX 4 – ADVICE FOR PATIENTS/CARERS WITH PEG/GASTRO TUBE

Advice for Patients/Carers with PEG/Gastro Tube

Tube Falls Out	**DRI and Montagu Patients** Contact Emergency Practitioners (ECPs) direct for immediate replacement. **Tel No. 08448 706800** **Bassetlaw Patients** Contact Single Point of Access to arrange immediate replacement **Tel No 01777 274400**
Wound Care	Contact Nutricia Nurse direct for advice **Tel No. 08456 623644**
Blocked Tube	Contact Nutricia Nurse direct for advice **Tel No. 08456 623644**
Spare Accessories Connectors	Contact Nutricia Nurse direct for advice **Tel No. 08456 623661**
Training	The Dietitian will contact the Nutricia Nurse **Tel No. 01302 366666 Ext. 4110**
To re-arrange appointments and planned gastro tube changes	**DRI and Montagu Patients** Contact Emergency Practitioners (ECPs) direct for immediate replacement. **Tel No. 08448 706803** **Bassetlaw Patients** These are changed and planned by the Nutricia Nurse **Tel No. 08456 623644**

APPENDIX 5 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Percutaneous Endoscopic Gastrostomy (PEG)/Enteral Tube Care Policy	Surgery and Emergency Care	Debi Oxley	Existing Policy	26.03.2015

1) Who is responsible for this policy? Name of CSU/Directorate Surgery and Emergency Care

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? The aim of the policy is to ensure that all patients receive a high standard of evidence-based practice throughout the Trust before, during and following the placement of an enteral feeding tube. This policy excludes nasogastric and naso-jejunal tubes. The policy will provide guidance to the multi-disciplinary Team (MDT).

3) Are there any associated objectives? To meet National Patient Safety Agency (NPSA) 2010 Rapid Response Report.

4) What factors contribute or detract from achieving intended outcomes? – None

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] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken] No

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

Date for next review: **March 2016**

Checked by: **Kirsty Clarke** **Date: 26.03.2015**