



Enteral Tube Feeding

Introduction

Supporting participants to eat naturally by oral means is always preferred. However, some people cannot eat or drink safely or are at risk of malnutrition. These problems are often associated with:

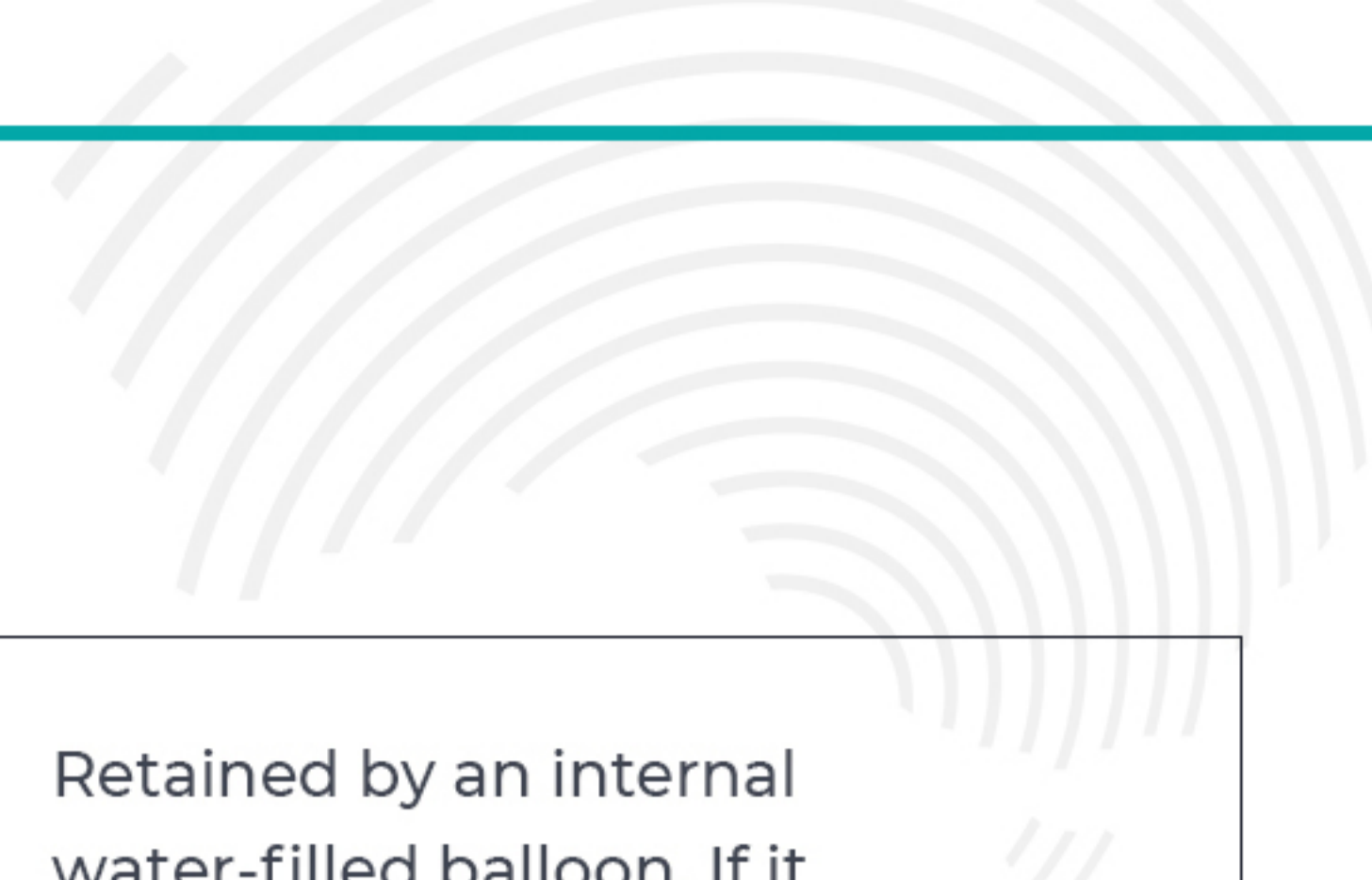
- Neuromuscular disorders that affect chewing and swallowing coordination that may result in aspiration (e.g. dysphagia associated with cerebral palsy, motor neurone disease, brain injury, Huntington's disease, stroke)
- Medical problems and/or structural abnormalities of the gastrointestinal tract, e.g. inflammatory bowel disease, cancers, hepatic, renal or respiratory failure, anorexia, HIV/AIDS
- Cognitive impairments that affect capacity to coordinate chewing and swallowing safely
- Fatigue associated with illness
- Failure to thrive or severe reflux in infants
- Reduced level of consciousness.

Enteral tube feeding can provide nutrition to a person at risk of malnutrition and/or choking. It can be used to:

- Administer bolus, intermittent feeds or continuous feeds
- Administer medication
- Facilitate free drainage and aspiration of the stomach contents
- Facilitate venting/decompression of the stomach.

There are many types of enteral feeding tubes, this policy covers the most commonly used as described in the table below.

	Tube type and size	Insertion method	Uses	Key management points
Nasogastric tube (NGT)	8Fr 110cm	Usually bedside, by a suitable qualified professional	For short term feeding (up to a month) or when a longer term option is deemed n/a	Position in stomach must be verified before every use with pH paper. Liable to block—if not managed appropriately. Relatively easy to replace.
Nasojejunal tube (NJT)	8Fr	Endoscopic	For short term post pyloric feeding (when n/a to feed into the stomach) (up to a month) or when a longer term option is deemed n/a	Position verified by measurement. Liable to block if not managed appropriately. Replaced in endoscopy.
Percutaneous endoscopic gastrostomy (PEG)	Freka PEG 15Fr	Endoscopic	For long term (>4 weeks) gastric feeding in persons able to undergo endoscopy with sedation	Most common long term feeding tube. Risk of buried bumper leading to surgical intervention. Needs daily advancing and rotating to prevent buried bumper.



Radiologically inserted gastrostomy (RIG)	Balloon gastrostomy tube 14Fr	Radiology	For long term (>4 weeks) gastric feeding in persons unable to undergo endoscopy with sedation—because they cannot be ‘scoped or because of poor respiratory function.	Retained by an internal water-filled balloon. If it falls out must be replaced within 2-4 hours. Tube needs changing every 3-6 months.
Jejunostomy tube	Balloon gastrostomy tube or a specific surgical jejunostomy tube	Usually surgery	For long term (>4 weeks post pyloric feeding in persons able to undergo a surgical procedure	For balloon retained tubes, management is as for RIG. Surgical tubes may be retained with a Dacron cuff or sutures.

Participants should always be involved in decisions that affect them including whether to use a feeding tube. This should be decided together with the participant’s family/carer/guardian after assessment by a speech pathologist, dietitian, gastroenterologist and/or paediatrician.

Where nutrition intake is the concern, tube feeding may supplement a person’s oral intake. However, if there are safety concerns for a person with severe dysphagia and chronic aspiration, all nutrition and hydration is administered via tube.

Applicability

When

- Applies when participants are supported that need enteral tube feeding.

Who

- Applies to all employees, supervisors and key management personnel supporting participants with enteral tube feeding needs.

Documents relevant to this policy

- Enteral tube feeding (easy read)

Tube feeding assessment

Assessing participants for tube feeding needs:

- Assess all participants during the entry process for nutrition and swallowing as part of a comprehensive health assessment, which is reviewed at least yearly (or more often if there are significant changes to a participant’s health)
- Decisions on whether to use tube feeding must be person-centred and involve the participant, their family, carer, guardian
- The person-centred assessment should assess the participant’s home environment and lifestyle
- Participants should be provided additional support when making decisions about tube feeding such as specialised advice from a dietician
- Participants that require tube feeding will be involved in making an enteral feeding management plan that suits the individual
- Participants being tube fed should be provided opportunities and supported to enjoy oral intake
- Only workers trained in tube feeding can support participants with tube feeding



Interventions and incident reporting

All workers and key management personnel must be aware of potential problems and appropriate corrective measures for participants receiving enteral tube feeding.

Serious complications include: tube dislodgement, septicaemia, nausea and vomiting, imbalanced nutrition, fluid and electrolyte imbalance, dehydration.

Common problems include:

- Occlusion of feeding tubes (blockages)
- Vomiting and or aspiration—caused by improper tube placement, delayed gastric emptying, contamination of formula
- Diarrhoea—feeding too fast, lactose intolerance, contamination of formula
- Constipation—formula components, poor fluid intake, medication effect.

Managing enteral tube feeding is complex care. Seek advice of healthcare professionals if needed. Close consultation with nutritional support experts can address and resolve issues.

Worker responsibilities when supporting participants with tube feeding

Responsibilities for workers are to:

- Provide best practice guidelines for management of participants receiving enteral feeding
- Maintain both knowledge and problem-solving skills and a willingness to provide reassurance to participants and seek help when needed
- Practice good hand hygiene and wear PPE as required
- Accurate documenting including:
 - A. Input and output
 - B. Formula/feed labelled with date and time opened
 - C. Baseline weight and weekly weight of participant
 - D. Condition of skin around nasal cavity and lining for redness or maceration
 - E. Due date for change of pump tubing (as per manufacture's guidelines)
- Ensure feeding tubes are kept clean and are flushed before and after feeding or medication
- Confirm feeding tubes are in the correct place before any feed or medication is given
- Feed participants according to their tube feeding management plan and the enteral tube feeding process
- Promote healthy oral hygiene in participants with no oral intake
- Maintain clean work surfaces and proper disposal of equipment and waste
- Minimise complications with enteral tube feeding:
 - A. Use liquid medications rather than pills
 - B. Dilute viscous liquid medications
 - C. Discard outdated formula
 - D. Follow general principles of tube feeding e.g. elevating head of bed and position participant comfortably
 - E. Flush feeding tubes regularly to maintain tube patency before and after bolus feeds, administration of medications
 - F. Assess regularly for complications e.g. aspiration, diarrhoea, constipation.



Key management personnel responsibilities when supporting participants with tube feeding

- Ensure workers supporting participants with tube feeding are trained and confident to provide this support
- Ensure participants are provided information about tubes, feeding, the purpose and possible complications so that they
- Can make decisions based on correct information
- Ensure workers' education and training covers:
 - A. positioning of the person
 - B. medical administration
 - C. infection control
 - D. flushing of feeding tubes
 - E. care of insertion site
- Regularly audit enteral tube feeding management practices
- Provide template for recording data including specific medical orders
- Provide information about complications of enteral feeding and escalation in an emergency