

TIP SHEET FOR TUBE FEEDING

Tube feeding may be clinically appropriate in certain circumstances, but it should not be an automatic next step when other feeding strategies have failed. Before deciding to initiate tube feeding, the interdisciplinary care team should meet with the patient and family to carefully consider the risks and benefits of tube feeding and the patient's preferences. - AMDA Clinical Practice Guideline for Alteration in Nutritional Status, 2010.

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Best Practices for Tube Feeding

Hand hygiene and aseptic techniques should be in place to prevent contamination of formula.

Perform oral care routinely to decrease oral bacterial colonization and, subsequently, reduce the risk of health care-acquired pneumonia.

Skin care – Cleanse feeding tube site with soap and water daily, and routinely observe for signs of excoriation or infection.

“A decision to use a feeding tube has a major impact on a resident and his or her quality of life. It is important that any decision regarding the use of a feeding tube be based on the resident's clinical condition and wishes as well as applicable federal and state laws and regulations for decision making about life-sustaining treatments.” - CMS Letter (S&C) 9/27/2012 Feeding Tubes

PROCEDURES

- ✓ Change Feeding Set/Bag/Syringe/ Connector as specified
- ✓ Prior to bolus feedings, or every 8 hours, confirm feeding tube placement and patency. Draw 5 to 10 mL of air into a syringe. Place stethoscope on the left side of the abdomen, above the waist. Attach syringe to the feeding tube, inject air and listen to the stomach for air rush, gurgling and or growling.
- ✓ Administer formula as ordered – verify product, rate, and feeding schedule.
- ✓ Do not mix medications with formula. Flush feeding tube with 30 ML of H₂O before and after medication administration and 5 ML between each medication or as ordered.
- ✓ Administer flushes as ordered - verify amount and scheduled times. Water is the preferred flush.
- ✓ Fill the enteral feeding bag and then purge any air from the administration tubing. If a prefilled feeding container is available, attach it to the administration set and then purge any air from the tubing.
- ✓ Replace enteral feeding administration sets for open-system enteral feedings at least every 24 hours.
- ✓ Closed-system formulas can hang for 24 to 48 hours, according to the manufacturer's guidelines.
- ✓ Typical mechanical problems include enteral feeding tube dislodgment, obstruction, and impairment. For example, a feeding tube may migrate if the external bumper loosens. Occlusion may result from incompletely crushed and liquefied medication particles or inadequate tube flushing. The tube may rupture or crack from age, drying, or frequent manipulation. If the tube needs to be changed, verify the type and size of the tube.



- While feeding is infusing, elevate head of bed as resident tolerates 30-45 degrees to reduce the risk of esophageal reflux and pulmonary aspiration unless otherwise specified in medical orders or contraindicated for other reasons.
- Check gastric residual volume before bolus feedings, and as ordered for continuous feedings by pump.

INTOLERANCE OF TUBE FEEDING

- If the gastric residual volume is 240 ml or greater after a second gastric residual check, a promotility agent should be considered in adult patients.
- A gastric residual volume greater than 500 ml should result in holding enteral nutrition and reassessing tolerance by reviewing physical assessment, GI assessment, evaluation of glycemic control, minimization of sedation, and consideration of promotility agent use, if not already prescribed.
- Cramping, nausea, vomiting, bloating, and diarrhea may be related to the following: medication; rapid infusion rate (dumping syndrome); formula contamination, osmolarity, or temperature (too cold or too warm); fat malabsorption; or intestinal atrophy from malnutrition.
- If the person vomits, complains of nausea, feels too full, or regurgitates, stop the enteral feeding immediately and assess his condition.
- Constipation may result from inadequate hydration, low fiber intake, fecal impaction, or electrolyte and hormonal imbalance.



References:

Bankhead, R., et al. (2009). A.S.P.E.N. enteral nutrition practice recommendations. *Journal of Parenteral & Enteral Nutrition*, 335, 122–167.

Fundamentals of Nursing, 8th edition, 2015

