Enteral Feeding
Policy, Guidelines & Framework

Current Version

Service Area	Disability, Aged, Community	**Version**	1.1
Process Owner	Governance Lead | CEO | COO	**Date of Issue**	May 2023
Approved by	Chief Executive Officer	**Review**	May 2025

Modification History

Version	Date	Author	Approved by	Description of change
1.0	5/2018	Natashia Telfer	Employsure	Broaden coverage across community
1.1	5/2020	Tahla Small	CEO	Redevelopment for clinical support

In conjunction with:

- NCC Policies

Contents

Enteral Feeding Policy

POLICY STATEMENT
SCOPE
This policy applies to all employees of National deemed competent to provide enteral feeding care.

POLICY
Taken directly from the DAA (2018) Enteral nutrition manual for adults in health care facilities

What is enteral nutrition

Enteral nutrition is defined as the introduction of a nutritionally complete liquid formula directly into the stomach or small intestine via a narrow, often specifically designed, tube.

When is enteral nutrition indicated

Enteral nutrition is considered when an individual cannot safely manage oral intake, an example of this is in individuals with dysphagia, reduced level of consciousness or when oral intake is not adequate to meet their nutritional requirements.

Routes of Enteral feeding

- Nasogastric, nasoduodenal or nasojejunal
- Percutaneous enteric tubes (gastrostomy or jejunostomy)
- Trans-oesophageal feeding ("TOF") or oesophagostomy tube

Equipment

The following equipment involved in enteral feeding may include the following:

- Enteral feeding tube
- Administration reservoir (Feed bag, bottle, etc)
- Giving set
- Syringes
- Enteral pump

All equipment is to be used, cleaned and disposed of as per manufactures instructions.

Dietitian enteral regimes

- National Community Care staff are to adhere to client/participant's dietitian developed enteral regimes, as per clinical care plan. These plans are reviewed monthly and/or when required in coordination with the dietician and other health professionals.
- Staff are to ensure they attend required documentation post implementing enteral regimes.

National Responsibilities

- To provide staff with annual best practice training according to the staff members scope of practice.
- To source a training provider in line with demand for additional identified supports
- To coordinate with staff any changes in enteral feeding regimes in a timely and effective manner to ensure client/participant safety.
- Ensure required equipment is available for trained staff to use for enteral feeding.

RN Responsibilities

- Adhere to the client/participants enteral regime designed by dietician in consultation with client/participant.
- Provide clinical feedback on effectiveness of regime to dietitian in a timely manner.
- Monitor delivery of enteral regime, when enteral regime is being attended by a competent carer, provide oversight during the process.
- Monitor stoma site for signs of redness, leaking and offensive odour / exudate and report to general practitioner in a timely manner.
- Monitor for signs of intolerance to feed regime, such as pain, bloating, vomiting etc
- Action signs of intolerance immediately through consultation with dietician.
- Monitor fluid balance charts.
- Documentation.
- Cleaning of equipment as per manufacturer recommendations.
- Attend incident reports and inform Clinical coordinator in a timely manner.

AIN Responsibilities

- Assist registered nurses with implementing enteral regime within their scope.
- Monitor clients for intolerance of enteral regime and report to registered nurses.
- Attend fluid balance charting at the time of input and output.
- Monitor stoma site for signs of leaking, redness or offensive exudate and report to registered nurses for action.

Training Requirements

- All service delivery employees delivering and/or intending to deliver enteral feeding services are required to hold a competency in the field.
- Community employees are to have a watch and learn buddy shift and a show and do buddy shift
- Attend individualised client competency at client discretion with assessor competency
- Employees are required to undertake an annual refresher. This may be through face-to face training delivery, workshop, and/or online eLearning module in conjunction with workplace competencies.

PEG Procedure

What is a PEG - A gastrostomy feeding tube is one which has been inserted directly through the abdominal wall into the stomach and is commonly used for long term enteral support. Most gastrostomies are inserted by the percutaneous endoscopic technique (PEG), but they may also be placed surgically or radiologically. Gastrostomy tubes vary in size from 9-28F, and normally last for 18 months to 2 years.

The external fixation plate or flange on a gastrostomy tube keeps the tube from rubbing around the PEG site, protecting the skin from damage, and also prevents the tube from being drawn further into the gut by peristalsis. It should not be removed, and if faulty should be replaced. It is important that a patient's tube is correctly identified (type of tube, size, and manufacturer) by staff caring for the patient, and that these details are documented in the patient's notes. This allows appropriate care, and replacement parts to be provided when required. For example, a balloon gastrostomy should be checked fortnightly to ensure that the balloon is inflated with the correct amount of water, following manufacturer's instructions.

Care of the PEG tube

PEGs can become encrusted with feed or medications, and colonised with bacteria or yeasts, if not flushed regularly. This can result in damage to the tube, and the need for premature replacement. Even when the PEG is not currently being used for feeds (e.g. if it has been inserted prophylactically before radiotherapy starts) it should be flushed with water at least once per day.

Taking care of the PEG site is important to reduce the risk of skin breakdown and infection – the site is really a type of wound, and as such it is normal for the skin to be slightly red around the edge of the hole. Other than this slight redness, within a few days after insertion a healthy PEG site should look like normal skin, without excessive irritation, pus or blood. After the initial PEG insertion, endoscopists' instructions may vary.
Generally the PEG tube is rotated for the first time 24 hours after insertion, and the external flange left in its initial (quite tight) position for the first 5-7 days to encourage tract formation, after which it can be loosened to allow 1-2 mm movement in and out.

The PEG site should be washed daily as part of normal hygiene using warm soapy water, and then rinsed and dried thoroughly. The external flange will need to be lifted to clean around the tube. Unless the tube has been stitched into place, it should be gently pulled in and out (1-2 mm only) and rotated through one full turn daily.

The PEG site should not be covered with a dressing or ointments, as this can cause dampness, skin damage and infection. Leaving a long PEG tube dangling can also cause the side of the tube or the flange to rub and damage the skin so it may be helpful to keep it still by taping the end of the tube to the abdomen, or keep it tucked into underclothing between feeds.
Raised red hypergranulation tissue ('proud flesh') can sometimes develop, possibly due to friction from the tube. This is relatively common but can cause problems with the fit of the tube and becomes prone to infection, so should be treated promptly. Cauterisation with silver nitrate is the most common method - refer to medical team or wound care nurse.

Flushing an enteral tube regularly (usually 4-6 hourly during continuous feeding) is essential to ensure tube patency and minimise the risk of tube blockage, as well as to meet the patient's fluid requirements. Water at room temperature is considered the accepted flushing fluid and there is no evidence presented that tap water flushes in reasonable volumes pose any risk to humans.

However sterile water for irrigation, commercially filtered or cooled boiled tap water have been suggested for use in particular patients who may be at increased risk. This would include immunocompromised patients and those being fed postpylorically.

Post pyloric feeding bypasses the acidic environment of the stomach, which normally provides protection against bacteria. Where possible any drugs administered via an enteral feeding tube should be liquid and given separately from the feed, with flushing of the tube before and after each separate medication.

Flush tubes regularly with at least 30mls of water before, between and after medication administration, before and after bolus feedings and before and after checking gastric residuals and when feeds are stopped.

- Smaller bore tubes such as jejunal tubes and fine bore tubes are more prone to clogging and may need to be flushed more frequently – very warm water (drinkable tea/coffee temperature) may help to prevent coagulation of feed residue.
- When several drugs are to be given, each should be given separately with a 5-10ml water flush given between each drug
- Use a 60ml syringe for flushes as smaller syringes may exert a force great enough to damage the tube
- Additional water flushes or increased volumes may be required, to meet the patient's hydration needs. Normally the patient's fluid requirements are estimated and the tube flushes are used to meet these (taking into account other fluids being given, and the water content of the tube feed formula). Flush volumes are then adjusted as needed, to achieve optimal fluid status.
- Avoid flushing with acidic fluids (fruit juices or carbonated drinks like cola/soda water/mineral water), which can make the chance of blockages more likely. There is no evidence supporting the use of any fluid other than very warm water to unblock tubes.

REFERENCES

Dietitians Association of Australia, Nutrition Support Interest Group, 2015, Enteral nutrition manual for adults in health care facilities, accessed from daa.asn.au/wp-content/uploads/2015/04/Enteral-nutrition-manualJanuary-2015.pdf on 5 April 2018.
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