ENTERAL FEEDING CLINICAL GUIDANCE

RATIFYING COMMITTEE: Corporate Procedural Document Review Group

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POLICY STATEMENT:

ACCOUNTABLE DIRECTOR: Executive Director of Nursing & High Secure Services

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Modern Matron, Physical Health

KEY POLICY ISSUES

- Nutrition and feed types
- Feeding routes and method of delivery
- Administering enteral feeding and medicines
- Equipment use in enteral feeding
- Clinical standards associated with the practice of enteral feeding
- Prevention of Infection
- Monitoring a patient receiving enteral food
- Guidance on how to deal with problems associated with enteral feeding
- Oral hygiene and mouth care
- Record keeping and fluid balance
- Care of the diabetic patient receiving enteral food
- Guidance on Emergency feeding

This document can be made available in other formats upon request
With thanks to the Dietetic Departments of West Middlesex University Hospital and Charing Cross Hospital and West London Mental Health NHS Trust
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1. EXECUTIVE SUMMARY

‘Enteral feeding’ is a means of delivering nutrition into the gastrointestinal tract through a tube, either via the nose or directly into the stomach or small intestine through a stoma in the intestinal wall. This method of feeding is only necessary/desirable when a patient’s nutritional needs cannot be met orally, for various possible reasons.

The Enteral Feeding Clinical Guidance document has been developed for all Medical, Nurses and Health Care Professionals (with the skills and completed training to care for patients who are enterally fed), to act a point of reference or guide: To ensure they act in a safe and effective manner to minimalise all potential risks and harm to the patient. The guidance covers all aspects of multi-disciplinary care for patients being enterally fed, as follows:

• Introduction
  - Indications for Enteral Feeding
  - Decision to feed and feeding against the will of the patient

• Feeding routes and method of delivery
  - Short term and Long-term feeding
  - Method of delivery
  - Type of feed
  - Fluid

• Process of administering enteral feeding and medicines
  - Detailed description of the process of tube insertion and confirming position of tube and preventing aspiratin
  - Use of enteral feeding pump or bolus to administer feed
  - Equipment use in enteral feeding
  - Determination of the risk of refeeding syndrome and resulting action
  - Clinical standards associated with the practice of enteral feeding
  - Suitable drugs and process of administration via the tube

• Infection prevention and control
  - Referring to clinical practice, equipment

• Monitoring a patient receiving enteral food
  - NICE protocol for nutrition, anthropometric and clinical monitoring of nutrition support
  - Oral hygiene and mouth care
  - Care of the diabetic patient receiving enteral feeding
  - Transition from enteral feeding to oral feeding

• Guidance on how to deal with problems associated with enteral feeding
  - Troubleshooting for enteral feeding devices
  - Physical symptoms caused by tube, pain, bowel problems, various other possible side-effects and feeding equipment problems
• **Recording and Documentation**
  - All stages of enteral feeding should be documented
  - Fluid should be recorded on fluid balance charts

• **Training**
  - Evidence from health professionals on ongoing competence in insertion, administration of feed and tube care needed
  - Annual updates required and assessed.

• **Emergency feeding Guidelines**
  - Feeding guidelines (feed, regimen etc) to follow if a dietitian is not available to commence feeding
  - To be reviewed by a dietitian ASAP

2. **VERSION CONTROL**

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Approved by</th>
<th>Ratified by</th>
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3. **INTRODUCTION**

These guidelines are intended for use when caring for patients who are not seriously physically ill, but who require enteral feeding. At all times care must be taken to ensure the safety of the patient and staff.

Enteral feeding is a means of delivering nutrition into the gastrointestinal tract through a tube, either via the nose or directly into the stomach or small intestine through a stoma in the intestinal wall.

These guidelines are informed by NICE Clinical Guideline 32: *Nutrition support in adults* (February 2006). The NICE guidelines do not specifically cover patients with eating disorders/food refusal, because the aims of intervention differ significantly from those with malnutrition related to physical disease.

4. **INDICATIONS FOR ENTERAL FEEDING**

Whenever possible, oral food intake is always preferred. Enteral feeding is only necessary/desirable when a patient’s nutritional needs cannot be met orally, for example in:

- Food/fluids refusal or hunger strike
- Psychiatric disease e.g. anorexia nervosa, severe depression

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• Neurological problems, when energy requirements may be increased e.g. Huntington’s disease
• Swallowing disorders (dysphagia)
• Stroke or head injury
• Head and neck cancer
• GI dysfunction or malabsorption
• Upper GI obstructions
• Specific treatments, e.g. Chrons

Indications for enteral feeding in patients with a functional and accessible gastrointestinal tract but inadequate oral intake are:

- Patient has eaten little or nothing > 5 days, and/or is likely to eat little or nothing for the next 5 days or longer
- Unintentional weight loss >10% within the previous 3 to 6 months
- BMI<18.5 kg/m²
- BMI<20 kg/m² and unintentional weight loss >5% within the previous 3 to 6 months.
- Patient has poor absorptive capacity, is catabolic and/or has high nutrient losses
- Patient with weight loss consistent with the above AND who lacks the mental capacity to make an informed decision in respect of food/fluid intake
  AND/OR
- Patient detained under the Mental Health Act 1983 whose refusal to refuse food/fluids is linked to her/his mental disorder

Screening for malnutrition and the risk of malnutrition should be carried out when there is clinical concern. It should be carried out by healthcare professionals with appropriate skills and training. Screening should assess Body mass Index (BMI) and percentage unintentional weight loss, and should consider the time over which nutrient intake has been unintentionally reduced and/or the likelihood of future impaired nutrient intake. (NICE Clinical Guideline 32 Feb.2006 Nutrition Support in Adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition.

4.1 Decision to feed enterally

The decision to feed enterally is made by the multidisciplinary team in consultation with the client and his/her family, if possible. Healthcare professionals should act in the patient’s best interest if he or she is not competent to give consent. (NICE Clinical Guideline 32 Feb.2006 Nutrition Support in Adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition –

4.2 Feeding against the will of the patient

Feeding against the will of the patient should be an intervention of the last resort in the care and management of those with severe eating disorders or other mental illness. It should be considered in the context of the Mental Health Act 1983, the Mental Capacity Act 2005 or the Children Act 1989 (and their respective Codes of Practice).
Where the Mental Capacity Act 2005 is used to authorise enteral feeding the patient should be assessed to see if additional authorisation under the Deprivation of Liberty Safeguards apply.

All mental capacity assessments must be Mental Capacity Act 2005 compliant (please refer to Trust policies MC01 – MC04 inclusive).

For a detailed analysis and step-by-step guidance to the administration of enteral feeding in all circumstances, please refer to Appendix 7 (?): MENTAL CAPACITY, CONSENT & HOSPITAL IN-PATIENT ADMISSION FOR THE ASSESSMENT, CARE and TREATMENT OF ENTERAL FEEDING.

For High Secure Services where there is an incident that includes food refusal or hunger strike then the local procedure HSS 08 – Guidelines for food and fluid refusal should be followed.

5. FEEDING ROUTES

Enteral feeding is most commonly used to place feed into a patient’s stomach. When necessary it is possible to feed directly into the duodenum or jejunum (small intestine). The route and type of appliance used will depend on the individual circumstances of the patient.

5.1 Short term feeding (up to 4 weeks)

5.1.1 Nasogastric tube feeding (NG)

A fine bore feeding tube (French gauge 5-8) is inserted via the nose into the stomach. An example is Merck Corflo 8 French (weighted) 92 cm. Bolus or pump feeding can be used with an NG tube. Long term fine bore tubes should be replaced every 4-6 weeks, swapping them to the other nostril. Regular checks of NG tube placement are imperative as there is a risk that tubes can be misplaced into the lungs on insertion or move from the stomach at a later stage. (see section 7).

5.2 Long term feeding (longer than 4 weeks)

5.2.1 Percutaneous endoscopic gastostomy (PEG)

The feeding tube is placed into the stomach through an abdominal stoma. Gastrostomies are commonly placed endoscopically by a method called percutaneous endoscopic gastrostomy (PEG) and are retained in the stomach by a flange. Gastrostomies can be placed surgically or radiologically, if necessary.

5.2.2 Button gastrostomy

This is a small tube that has the same function as a PEG but the button is flush with the patient’s abdomen and less conspicuous. The button is held in place by a small
balloon inside the stomach and the balloon needs to be checked weekly. Button gastostomies are used more frequently in children than adults.

5.2.3 Gastrojejunostomy

This is an endoscopically placed extension of a PEG. The extension is passed through the PEG into the stomach and down past the pylorus into the jejunum. These are used if there is a problem with the stomach or gastric emptying.

6. METHOD OF DELIVERY

The Dietician, in consultation with doctors and other health professionals, will decide on feed type and method of delivery. Factors considered are:

- Patient’s current and past nutritional status
- Feeding environment
- Reason for feeding enterally
- Proposed time period of enteral feeding
- Any complications present
- Patient wishes

A written regimen specifying feed, rate of feeding, and additional water flushes will be provided by the Dietician. Sample feeding regimen sheets are in Appendix 1.

6.1 Infusion (feed delivered by pump)

Pumps can be set to deliver feed at rates between 5 and 500 ml per hour. Feeds are usually begun at a low rate (about 50 ml/hr) and increased in stages to about 100 to 150 ml/hour after tolerance is demonstrated.

6.1.1 Continuous

Continuous feeding usually refers to feeding over 16-20 hours. Continuous feeding is used if a patient is unable to tolerate large volumes of feed. It can be used initially and the patient may progress onto an intermittent infusion regime. The feed may be delivered overnight or during the day depending on the individual patient's needs and tolerance. Continuous feeding usually includes a break of at least 4 hours in 24 hours to allow the stomach to re-acidify. 24 hour feeding is used in critical care or patients on a sliding scale insulin.

6.1.2 Intermittent

This involves periods of feeding using the pump with breaks.

6.2 Bolus feeding(without pump)

Bolus feeding involves the delivery of 100mls to 300mls over a period of 10-30 minutes and can be given 4-6 times a day depending on the patient's individual feeding regime. Administration can be with a syringe using only the barrel as a funnel to allow the feed to infuse using gravity. The plunger from the syringe
should not be used to push feed through. Bolus feeding can also be administered with bolus feed gravity sets. If there are any signs of intolerance then another feeding method should be sought.

If administering medication via enteral feeding system as a bolus, the correct safety devices and connector combinations should be used at all times, ensuring that three way and syringe tip adaptors
Patient Safety Alert19, March 2007

7. TYPE OF FEED

A wide variety of feeds is available. Sterile packs of feed are preferable to those that need decanting as there is less risk of contamination. The Dietician will choose the most suitable feed depending on the individual needs of the patient. Feed should be stored in a cool dry place, off the floor and away from direct sunlight.

Standard whole protein feeds such as Osmolite provide 1 kcal/ml, while Jevity 1.5kcal provides 1.5 kcal./ml. High energy feeds are useful when fluid is restricted or to reduce feeding time. Most feeds are lactose, gluten and wheat free, and suitable for vegetarians.

Diabetics are usually given standard formulas but should be monitored frequently. See the section on Monitoring for guidance. (see section 14)

8. FLUID

Feeding tubes should be flushed with water before and after administration of feed, medication and in between medications.

This helps to prevent blockage of the tube while also contributing to overall fluid contents.

Full fluid requirements can usually be met by feed and flushes, although additional flushes may be requested to meet the patients daily fluid requirements. If IV fluids are also being given, these must be taken into account.

The dieticians should be informed of any ongoing loss of body fluids eg diarrhoea, seepage from burns, excessive perspiration), so that the fluid content of the feed can be adjusted accordingly. This will involve an increase of 2 to 2.5mls / kg body weight for each °C rise in body temperature above 37°C. Some medical conditions require higher fluid intakes. When this is the case, a doctor will prescribe the necessary fluid.

9. NASOGASTRIC INTUBATION WITH TUBES WITHOUT USING AN INTRODUCER, e.g. A Ryle’s tube

It is recommended that a nasogastric tube designed for feeding purposes be used wherever possible, e.g. fine-bore feeding tube, rather than a Ryle’s tube which is used for drainage of gastric contents.
9.1 Recommendations for Practice – Staff Training and Competence

- A patient requiring NG tube insertion should be managed and supported by appropriately trained staff.
- Registered Nurses and Registered Medical Staff should ensure that they are involved in insertion and/or position checks that they have been assessed as competent through theoretical and practical training.
- Skills and competence should be reviewed annually and updated to reflect new practice in the management of NG tubes.
- Only 2 attempts should be made by 1 person to insert a NG tube. If the attempts are unsuccessful another experienced practitioner should retry.

9.2. Insertion of a Nasogastric Tube

Necessary equipment:
- Clinically clean receiver
- Fine bore nasogastric tube
- 50ml enteral syringe and 20ml enteral syringe
- Hypoallergenic tape
- Glass of water (if the patient is able to swallow) and is allowed fluids
- pH indicator strips (0.5 graduations).
- Personal Protective Equipment (PPE)- disposable gloves and apron
- Indelible marking pen

Passage of Nasogastric Tube

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
<th>EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Give a detailed explanation and obtain verbal consent.</td>
<td>To obtain the persons consent and cooperation</td>
</tr>
<tr>
<td>2</td>
<td>Ensure that the patient knows a Signal (e.g to raise hand) to Communicate that he/she wants the Nurse to stop.</td>
<td>The person is often Less frightened if He/she feels able to Have some control Over the procedure.</td>
</tr>
<tr>
<td>3</td>
<td>Help the patient to sit in a supported Comfortable upright position (55 – 65° angle) in the bed or chair Supported by pillows. NB The head Should not be tilted backwards. If Unconscious, place in a safe position By laying the patient in their side, do not extend the neck.</td>
<td>To allow for easy passage of the tube. This position enables easy swallowing and ensures the epiglottis is not obstructing the oesophagus.</td>
</tr>
<tr>
<td>4</td>
<td>Ensure strict hand hygiene is adhered to and PPE put on prior to commencing procedure.</td>
<td>To maintain hand hygiene to reduce the risk of contamination.</td>
</tr>
<tr>
<td>5</td>
<td>Standard Infection Control precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Should be used when performing procedure.</td>
<td>Control Policy</td>
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<td>------------------------------------------</td>
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<tr>
<td>6</td>
<td>Determine the length of tube required measuring from the nose to the ear lobe then to the xiphisternum and mark this length on the tube (limiting mark) with pen or tape. Where a guidewire is present, straighten the tube by stretching, this makes it easier to remove the guidewire afterwards. If present, ensure guidewire is fully locked on to the end of the NG tube. Lubricate the end of the tube with water-do not use lubricating gel as this gives an acid reaction. (CREST 2004)</td>
<td>To ensure that the appropriate length of the tube is passed into the stomach. Mallet J &amp; Dougherty L (2000)</td>
</tr>
<tr>
<td>7</td>
<td>If patient has intact swallow reflex- ensure a glass of water or bottle is available to sip in preparation for placement. If patient is ‘Nil by mouth’- they asked to repeatedly carry out a swallow action. But not take a drink.</td>
<td></td>
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<tr>
<td>8</td>
<td>Ask the patient to blow their nose if they able to clear the nasal passages. Check nostrils are patent by asking the patient to sniff with one nostril closed. Repeat with other nostril. Insert the rounded end of the tube into nostril, slide it backwards and inwards along the floor of the nose to the nasopharynx. Withdraw if any obstruction is felt, try again slightly different angle or use the other nostril. To facilitate the passage of the tube following the natural anatomy of the nose. To avoid trauma to the nasal passage.</td>
<td>To facilitate the passage of the tube following the natural anatomy of the nose. Pritchard et al (2004) Mensforth A Nightingale JMD (2001) Mallet J &amp; Dougherty L (2000)</td>
</tr>
<tr>
<td>9</td>
<td>As the tube passes into the nasopharynx ask the patient to start swallowing (or sip if able). A swallowing action closes glottis enabling the tube to pass into the oesophagus.</td>
<td>Mallet J &amp; Dougherty L (2000)</td>
</tr>
<tr>
<td>10</td>
<td>Advance the tube until you reach the point where the tube was measured marked. As the tube insertion proceeds observe patient and remove the tube if coughing, distress or cyanosis occurs. Withdraw tube as this may indicate tracheal placement. <strong>NB Maximum of 2 attempts.</strong> Check inside the mouth for a coil of tube if the patient is unable to communicate. Some patients do not have a cough reflex unrecognised entry to trachea may occur e.g Stroke. Neuro sedated and trauma patients.</td>
<td>Mallet J&amp;Dougherty L (2000)</td>
</tr>
<tr>
<td>11</td>
<td>Confirm correct placement of tube before removing guide wire by aspirating</td>
<td></td>
</tr>
<tr>
<td>Step</td>
<td>Instruction</td>
<td>Reason</td>
</tr>
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<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
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<tr>
<td>12</td>
<td>Care should be taken to ensure that the end of the tube is firmly closed with a spigot when not in use and that this is checked regularly.</td>
<td>To ensure that acidic gastric contents do not leak or siphon from the tube, resulting in caustic burns to the patients skin.</td>
</tr>
<tr>
<td>13</td>
<td>Measure the length of tubing remaining from the nostril to the tip (i.e visible tubing).</td>
<td>Give baseline against which to assess possible displacement.</td>
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<tr>
<td>14</td>
<td>Once the position has been confirmed, remove the guidewire. To remove guidewire attach a 20ml enteral syringe containing 10ml of water to the end of the tube and slowly inject the water down the tube. This activates the internal lubricant in the tube and aids removal. The tube should be held firmly at the tip of the nose to ensure that the tube stays in position as the guidewire is removed. <strong>The guidewire must be removed carefully. The guidewire must never be reinserted while the tube is still in the patient (CREST 2004)</strong></td>
<td>To maintain the tube in place. To ensure comfort.</td>
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<tr>
<td>15</td>
<td>Following successful insertion use an adhesive patch to anchor the tube securely to the cheek and hook it over the ear, keeping it out of the patient visual fields and avoiding friction to the nose. Where the adhesive patch proves unsuitable, use a barrier product such as a hydrocolloid dressing to protect the skin and a transparent dressing placed over this to hold the tube in place. Consider use of a nasal bridle to secure the NG tube if NG is frequently displaced (NICE Clinical Guidelines (32) 2006).</td>
<td></td>
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<tr>
<td>16</td>
<td>Remove PPE and decontaminate hands following NG tube insertion.</td>
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<td>17</td>
<td>At all times during the procedure talk to and reassure the patient.</td>
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<td>18</td>
<td>Document the procedure, size and type of tube and method used to confirm the position of the tube in the patients medical nursing notes.</td>
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<tr>
<td>19</td>
<td>Flush the tube with sterile water or flushes as per feeding regimen before commencing feeding.</td>
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### 9.3 Confirming Position of Nasogastric Tube

The NPSA Alert (March 2011) updates and strengthens Patient Safety Alert 05 (Reducing the harm caused by misplaced nasogastric feeding tubes).
Nasogastric tubes used for the purpose of feeding must be radio-opaque throughout their length and have externally visible length markings.

The length of the tube should be estimated before insertion using the NEX measurement. Place exit part of tube at the NEX of nose. Extend tube to earlobe and then to xiphisternum- known as the NEX measurement. Once inserted the external tube length should be recorded and confirmed before each feed.

First line test method: pH paper
- pH testings used as the first line test method with pH between 1 and 5.5 as the safe range, and that each test and test result is documented on a chart and kept at the patients bedside.- Appendix 3
- pH readings should be between 1 and 5.5 for feeding to commence safely.
- It is recommended by the NPSA that readings falling between pH 5 and 6 should be checked by a second competent person.
- All areas were NG feeding tube placement is likely to occur must have access to pH indicator paper that is CE marked and manufactured to test human gastric aspirate.
- All pH tests and test results must be recorded on a chart and kept at the patients bedside.- Appendix 4

Documentation following ph testing needs to include:
- Whether aspirate was obtained.
- What the aspirate ph was.
- Who checked the aspirate pH.
- When it was confirmed to be safe to administer feed and/or medication (e.g gastric pH between 1 and 5.5).

Second line testing method: X- Ray Confirmation

9.4 Preventing aspiration

The patient is at risk of aspiration of feed if the gastric contents leak up into the oesophagus. To help prevent aspiration of feed into the patients lungs, the head of the bed should be elevated by at least 30 degrees during feeding and for one hour after feed has finished. Patients at high risk of aspiration should be fed at 90 degrees and observed frequently.

9.5 Motility agents

If gastric residuals accumulate, there is increased risk of aspiration and/or vomiting. Patients with delayed gastric emptying should be offered a prokinetic agent to stimulate gastric emptying unless there is suspicion of gastrointestinal obstruction or a pharmacological cause.
10. ADMINISTERING ENTERAL FEEDS

10.1 Administration of feed using an enteral feeding pump

10.1.1 Equipment: Prescribed enteral feed (at room temperature)
- Pump
- Giving set
- Clean jug
- Sterile water/boiled cooled water
- 50 ml syringe
- pH sensitive strips
- Gloves and apron
- Drip stand

10.1.2 Procedure:

- Explain procedure to patient.
- Wash hands according to Trust policy and put on gloves and apron.
- Take the equipment to the patient’s bedside OR APPROPRIATE PRIVATE SPACE. The patient should be encouraged to assist in the procedure if possible.
- Close the clamp on the giving set.
- Check the expiry date on the feed. Shake the bag/bottle, twist off the cap and without touching the spike, tightly screw on the giving set which will break the foil seal.
- Hang the bag on the drip stand and prime the giving set, making sure there are no air bubbles.
- Connect the giving set to the feeding tube.
- Label the giving set with the date and time of changing. Change every 24 hours.
- Set the rate of administration as directed by the Dietician and press start.
- Flush tube pre and post feed as indicated on the feeding regimen sheet and record.
- Record amount of feed and of flushes given after each feed.
- Ensure the patient is comfortable observe for signs feeding intolerance
• Maintain patients position upper body at a minimum angle of 30 degrees for 1 hour. Ensure they do not lay flat.

10.2 Administration of bolus feed

10.2.1 Equipment:  Prescribed feed (at room temperature)
50 ml syringe
Alcohol wipes
Sterile water/boiled cooled water
Universal funnel adaptor
Gloves and apron
Clean jug

10.2.2 Procedure:

• Wash hands according to Trust policy, put on gloves and plastic apron.
• Flush feeding tube with 30-50 ml of sterile water using the 50 ml syringe.
• If feeding is via PEG, ensure clip on PEG is then reclosed.
• Check expiry date of feed and shake container before opening.
• Uncap end of tube/PEG, and connect funnel adaptor.
• Remove plunger from syringe and connect syringe to funnel adapter.
• Fill the syringe with feed using gravity to allow the feed to flow. Open clip on PEG and allow feed to flow through.
• Prior to syringe emptying, top up with feed until all has been given. Hold the syringe so that gravity is used to allow liquid into the stomach. If necessary, lower the syringe to a lower level to decrease rate of delivery. Do not allow the syringe to be completely empty before adding more feed.
• Flush tube with at least 30 ml or as regime of water.
• Close clip on PEG tube, remove funnel adaptor, syringe and recap PEG/NG tube end.
• Wash adapter and store. Clean syringe if it is to be reused.
• Store unused feed in a refrigerator, labelled with patient’s name, date and time of opening, and use with 24 hours.
• Record amount of feed given and flushes.
• Ensure the patient is comfortable observe for signs feeding intolerance.
• Maintain patients position upper body at a minimum angle of 30 degrees for 1 hour. Ensure they do not lay flat

Do not put anything down the tube that is not recommended by the dieticians

11. REFEEDING SYNDROME

Refeeding syndrome may occur when severely malnourished patients are fed enterally. There is a rapid fall in serum levels of phosphate, magnesium and potassium, along with altered glucose tolerance and an increased extracellular fluid volume. The resulting complications can include: respiratory failure, cardiac failure, cardiac arrhythmias, muscle wasting, seizures and coma.

Severely malnourished patients (see table below) require vitamin/mineral supplements prior to feeding and cardiac monitoring. They must be cared for by health professionals trained to deal with such cases. A flow chart for the care of such high-risk patients is given in Appendix 4.

**NICE (2006) criteria for determining patients at risk of refeeding problems**

<table>
<thead>
<tr>
<th>Patient has one or more of the following:</th>
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<tbody>
<tr>
<td>BMI &lt;16 kg/m²</td>
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<tr>
<td>Unintentional weight loss &gt;15% within the last 3 to 6 months</td>
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<tr>
<td>Little or no nutritional intake for &gt;10 days</td>
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<td>Low levels of potassium, phosphate or magnesium prior to feeding</td>
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**OR patient has 2 or more of the following**

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<tbody>
<tr>
<td>BMI &lt;18.5 kg/m²</td>
</tr>
<tr>
<td>Unintentional weight loss &gt;10% within the last 3-6 months</td>
</tr>
<tr>
<td>Little or no nutritional intake for &gt;5 days</td>
</tr>
<tr>
<td>A history of alcohol abuse or drugs including insulin, chemotherapy, antacids or diuretics</td>
</tr>
</tbody>
</table>

Refer patients to the dietitian that are at risk of refeeding syndrome before commencing enteral feed.

12. INFECTION PREVENTION AND CONTROL

Microbial contamination of feeds and equipment used in Enteral feeding can lead to serious infection.
Always wash hands thoroughly according to Trust policy before handling feeds and components of the feeding system.

- All equipment should be kept sealed in sterile packaging until use and handled minimally.

- Enteral feed stock should be rotated properly and stored off the floor in a cool dry place away from sunlight and heat.

- If a nasogastric tube is pulled out or accidentally displaced, it should not be reused.

- Enteral feeding tubes should be flushed regularly with at least 30 ml tap water using a 50 ml syringe and flushing should be documented: N.B. For immunocompromised patients sterile bottled water should be used.
  
  - every 4 to 6 hours during the day,
  - before and after feeding
  - before and after drug administration.

- Single patient use syringes should be discarded after 24 hours.

- Feed, feed reservoirs and giving sets must not be reused and should be discarded after 24 hours.. Ready to hang systems can hang for up to 24 hours.

- The feed reservoir must not be lowered below the level of the giving set to avoid reflux into the giving set.

- Opened containers of feed should always be kept refrigerated and used within appropriate time frame. There are recommendations for each feed. NB Allow feed to return to room temperature before use.

- Decanting into separate containers should be avoided (except in bolus feeding), as there is increased risk of contamination. Feed that has been decanted and hung must be thrown away after 4 hours.

13. ADMINISTRATION OF MEDICATION VIA A FEEDING TUBE

Check with pharmacy that any medication is suitable before administration.

When initiating an enteral feed, the patient’s medications must be considered to avoid possible drug/nutrient interactions and administration problems. Drugs to be administered through a feeding tube should be liquids or dispersible/soluble formulations. Pharmacy will also consider a number of issues including:

- Whether the feed reduces drug absorption or alters the pharmacokinetics
• If the rate of the feed needs to be adjusted to allow for drug absorption e.g. theophylline, phenytoin, penicillin, ciprofloxacin and oxytetracycline

• If there is an appropriate preparation available for the drug

• If the patient's drugs affect nutritional status e.g. diuretics, laxatives, IV fluids and nutritional supplements

13.1 Guide for administration of drugs

*Any drugs administered via a nasogastric tube should be given separately from the feed with flushing of the tube before and after.*

• Always use a 50 ml enteral syringe (purple) as small syringes cause too much pressure in the nasogastric tube.

• Flush tube with 30-50 ml water,

• Administer medication according to drug instructions from pharmacy.

• Flush tube again with another 30-50 ml of water.

• If a number of drugs are given at one time, flush with 30 ml of water between medications.

14. MONITORING

Healthcare professionals with relevant skills and training should review the indications, route, risks, benefits and goals of nutrition support at regular intervals. The time between reviews depends on the patient, care setting and duration of nutrition support. Intervals may increase as the patient is stabilised on nutrition support. (NICE Clinical Guideline 32 Feb.2006 Nutrition Support in Adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition The dietician must be regularly informed of any problems or changes.

NICE has provided comprehensive protocols for anthropometric, ie comparative body measurements which can be compared to standard measurements to determine body composition, , clinical and laboratory monitoring of nutrition support.

14.1 NICE protocol for nutritional, anthropometric and clinical monitoring of nutrition support

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Frequency</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrient intake from oral, enteral or parenteral nutrition (including any change in conditions)</td>
<td>Daily initially, reducing to twice weekly when stable</td>
<td>To ensure that patient is receiving nutrients to meet requirements and that current method of feeding is still the</td>
</tr>
</tbody>
</table>
**Enteral Feeding Guidelines**

- **affecting food intake)**
  - Most appropriate. To allow alteration of intake as indicated.

- **Actual volume of feed delivered**
  - Daily initially, reducing to twice weekly when stable
  - To ensure that patient is receiving correct volume of feed. To allow troubleshooting.

- **Fluid balance charts**
  - Daily initially, reducing to twice weekly when stable
  - To ensure patient is not becoming over/under hydrated.

### Anthropometric

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Frequency</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weight</strong></td>
<td>Daily if concerns regarding fluid balance, otherwise weekly reducing to monthly</td>
<td>To assess ongoing nutritional status, determine whether nutritional goals are being achieved and take into account both body fat and muscle.</td>
</tr>
<tr>
<td><strong>BMI</strong></td>
<td>Start of feeding and then monthly</td>
<td></td>
</tr>
<tr>
<td><strong>Mid-arm circumference</strong></td>
<td>Monthly if weight cannot be obtained or is difficult to interpret</td>
<td></td>
</tr>
<tr>
<td><strong>Triceps skinfold thickness</strong></td>
<td>Monthly if weight cannot be obtained or is difficult to interpret</td>
<td></td>
</tr>
</tbody>
</table>

### GI function

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Frequency</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nausea/vomiting</strong></td>
<td>Daily initially, reducing to twice weekly</td>
<td>To ensure tolerance of feed</td>
</tr>
<tr>
<td><strong>Bowel function</strong></td>
<td>Daily initially, reducing to twice weekly</td>
<td>To rule out diarrhoea and constipation and assess tolerance of feed</td>
</tr>
<tr>
<td><strong>Abdominal distension</strong></td>
<td>As necessary</td>
<td>Assess tolerance of feed</td>
</tr>
</tbody>
</table>

### Enteral tube – nasally inserted

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Frequency</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gastric tube position (pH &lt; 5.5 or noting position of markers on tube once initial position has been confirmed)</strong></td>
<td>Before each feed begins</td>
<td>To ensure tube in correct position</td>
</tr>
<tr>
<td><strong>Nasal erosion</strong></td>
<td>Daily</td>
<td>To ensure tolerance of tube</td>
</tr>
</tbody>
</table>
### Fixation (is it secure?)
- **Daily**
- To help prevent tube becoming dislodged

### Is tube in working order (all pieces intact, tube not blocked/kinked)?
- **Daily**
- To ensure tube is in working order

### Gastrostomy or jejunostomy
- **Stoma site**
  - **Daily**
  - To ensure site not infected/red, no signs of gastric leakage

- **Tube position (length at external fixation)**
  - **Daily**
  - To ensure tube has not migrated from/into stomach and there is no external over-granulation

- **Tube insertion and rotation (gastrostomy without jejunal extension only)**
  - **Weekly**
  - Prevent internal overgranulation/prevention of buried bumper syndrome

- **Balloon water volume (balloon retained gastrostomies only)**
  - **Weekly**
  - To prevent tube falling out

- **Jejunostomy tube position by noting position of external markers**
  - **Daily**
  - Confirmation of position

### Clinical condition
- **General condition**
  - **Daily**
  - To ensure that patient is tolerating feed and that feeding and route continue to be appropriate

- **Temperature/blood pressure**
  - **Daily initially and then as needed**
  - Sign of infection/fluid balance

- **Drug therapy**
  - **Daily initially, reducing to monthly when stable**
  - Appropriate preparation of drug (to reduce incidence of tug blockage). To prevent/reduce drug nutrient interactions

### Long/short-term goals
- **Are goals being met?**
  - **Daily initially, reducing to twice weekly and then progressively to 3-6 monthly, unless clinical condition**
  - To ensure that feeding is appropriate to overall care of patient
Are goals still appropriate? Daily initially, reducing to twice weekly and then progressively to 3-6 monthly unless clinical condition changes To ensure that feeding is appropriate to overall care of patient

### 14.2 NICE protocol for laboratory monitoring of nutrition support

This is particularly relevant to intravenous nutrition but may be selectively applied when enteral nutrition support is used for people who are metabolically unstable or at risk of refeeding syndrome.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Frequency</th>
<th>Rationale</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sodium, potassium, urea, creatinine</td>
<td>Baseline Daily until stable Then 1 or 2 times a week</td>
<td>Assessment of renal function, fluid status, and Na and K status</td>
<td>Interpret with knowledge of fluid balance and medication. Urinary sodium may be helpful in complex cases with gastrointestinal fluid loss</td>
</tr>
<tr>
<td>Glucose</td>
<td>Baseline 1 or 2 times a day (or more if needed) until stable Then weekly</td>
<td>Glucose intolerance is common</td>
<td>Good glycaemic control is necessary</td>
</tr>
<tr>
<td>Magnesium, phosphate</td>
<td>Baseline Daily if risk of refeeding syndrome Then three times a week until stable Then weekly</td>
<td>Depletion is common and under recognised</td>
<td>Low concentrations indicate poor status</td>
</tr>
<tr>
<td>Liver function tests including International Normalised Ratio (INR)</td>
<td>Baseline Twice weekly until stable Then weekly</td>
<td>Abnormalities common during parenteral nutrition</td>
<td>Complex. May be due to sepsis, other disease or nutritional intake</td>
</tr>
<tr>
<td>Substance</td>
<td>Baseline Pattern</td>
<td>Testing Frequency</td>
<td>Relevant Information</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------</td>
<td>-------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Calcium, albumin</td>
<td>Baseline, then</td>
<td>Hypocalcaemia or</td>
<td>Correct serum Ca concentration for albumin Hypocalcaemia may be secondary to Mg</td>
</tr>
<tr>
<td></td>
<td>weekly</td>
<td>hypercalcaemia</td>
<td>deficiency Low albumin reflects disease not protein status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>may occur</td>
<td></td>
</tr>
<tr>
<td>C-reactive protein</td>
<td>Baseline Then 2</td>
<td>Assists</td>
<td>To assess the presence of an acute phrase reaction (APR). The trend of results is</td>
</tr>
<tr>
<td></td>
<td>or 3 times a</td>
<td>interpretation of</td>
<td>important</td>
</tr>
<tr>
<td></td>
<td>week until</td>
<td>protein, trace</td>
<td></td>
</tr>
<tr>
<td></td>
<td>stable</td>
<td>element and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>vitamin results</td>
<td></td>
</tr>
<tr>
<td>Zinc, copper</td>
<td>Baseline Then</td>
<td>Deficiency</td>
<td>People most at risk when anabolic APR causes decreased Zn and increased Cu</td>
</tr>
<tr>
<td></td>
<td>every 2-4 weeks,</td>
<td>common, especially</td>
<td></td>
</tr>
<tr>
<td></td>
<td>depending on</td>
<td>when increased</td>
<td></td>
</tr>
<tr>
<td></td>
<td>results</td>
<td>losses</td>
<td></td>
</tr>
<tr>
<td>Selenium</td>
<td>Baseline if risk</td>
<td>Se deficiency</td>
<td>APR causes reduced Se. Long-term status better assessed by glutathione peroxidase</td>
</tr>
<tr>
<td></td>
<td>of depletion</td>
<td>likely in severe</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Further testing</td>
<td>illness and sepsis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>dependent on</td>
<td>or long-term</td>
<td></td>
</tr>
<tr>
<td></td>
<td>baseline</td>
<td>nutrition support</td>
<td></td>
</tr>
<tr>
<td>Full blood count</td>
<td>Baseline 1 or 2</td>
<td>Anaemia due to</td>
<td>Effects of sepsis may be important</td>
</tr>
<tr>
<td>and MCV</td>
<td>times a week</td>
<td>iron or folate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>until stable</td>
<td>deficiency or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Then weekly</td>
<td>folate deficiency</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>is common</td>
<td></td>
</tr>
<tr>
<td>Iron, ferritin</td>
<td>Baseline Then</td>
<td>Iron deficiency</td>
<td>Iron status difficult if APR (Fe↓, ferritin↑)</td>
</tr>
<tr>
<td></td>
<td>every 3 to 6</td>
<td>common in long-term</td>
<td></td>
</tr>
<tr>
<td></td>
<td>months</td>
<td>parenteral</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>nutrition</td>
<td></td>
</tr>
<tr>
<td>Folate, B12</td>
<td>Baseline Then</td>
<td>Iron deficiency</td>
<td>Serum/B12 sufficient with full blood count</td>
</tr>
<tr>
<td></td>
<td>every 2-4 weeks</td>
<td>is common</td>
<td></td>
</tr>
<tr>
<td>Manganese</td>
<td>Every 3-6 months</td>
<td>Excess provision</td>
<td>Red blood cell or</td>
</tr>
</tbody>
</table>
Patients that are stable on enteral feeds require annual bloods- UPE’s, LFT’s, FBC.

15. DIABETIC MONITORING

Illness increases blood glucose levels and enteral feeds are quickly absorbed. In diabetic patients, blood glucose should initially be monitored every 4 to 6 hours in case an increase in diabetic medication is required. Check medications with Pharmacy before giving via the feeding tube. Parenteral and Enteral Nutrition Group of the British Dietetic Association (PENG) Group Guidelines suggest that blood glucose be maintained between 5.5 - 11 mmol/l in stressed patients and then tightened to 5.5 – 8.5 mmol/l once control is established.

16. MOUTH CARE

Good oral hygiene is essential for patients receiving nutritional support or nil by mouth. Saliva is normally produced when eating and this helps keep the mouth clean. Since saliva production is often reduced when receiving nutritional support the oral mucosa can develop sores. Artificial saliva can help if the mouth is dry Patients should BE ENCOURAGED TO brush THEIR teeth regularly and use a suitable mouth rinse. Moisten the lips

17. TRANSITION FROM TUBE FEEDING TO ORAL FEEDING

Suitable oral food and fluids are started only after consultation and agreement with the clinical team. They will often be phased in as the feed is reduced to ensure that
adequate intake is maintained. The nutritional requirements of the patient will be calculated by the dietitian who can then advise on how to adjust the feeding regime.

If food refusal is the reason for enteral feeding, the tube may be removed when the patient decides to start eating.

18. TROUBLESHOOTING

Guideline for enteral feeding devices.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Nursing Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoma site is red and inflamed. (follow steps 1-3. Contact Abbott Nurse Advisor/ Nutrition Nurse Specialist for advice regarding steps 4-6)</td>
<td>1. The stoma should be cleaned initially twice daily with cooled boiled water or saline and gauze, paying attention to meticulous hygiene. 2. It is advised that the patient should not bathe or immerse the area in water while the stoma is healing (10-14 days). Showering is permitted provided the connector cap is fully closed and some effort is made to keep the stoma site dry. 3. After 2 weeks the patient may bathe as normal. 4. Always ensure the area is dried thoroughly afterwards to prevent infection. 5. If the stoma site becomes red and inflamed, take a swab of the site for microbiological culture. 6. Inform doctor, as antibiotics may be needed. 7. If site is infected with MRSA, it is recommended to use an antimicrobial solution e.g Octenisan® to wash the stoma and apply a dressing if appropriate. (Contact infection control team for advice).</td>
<td>Prevent infection occurring</td>
</tr>
<tr>
<td>Stoma site is leaking (Follow steps 1-4.</td>
<td>1. Ensure the external fixator (disc) is 1cm from the skin and the tube is secure (movement</td>
<td>Reduce leakage of gastric contents and excoriation to skin.</td>
</tr>
</tbody>
</table>
Contact Abbott Nurse Advisior or Nutrition Nurse Specialist for advice regarding steps 5-7

<table>
<thead>
<tr>
<th>of the gastrostomy in and out of the stomach will cause leakage of gastric contents.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Ensure the skin around the gastrostomy site is cleaned twice a day with saline and gauze for first 2 weeks, and then mild soap and water from then on, dried thoroughly.</td>
</tr>
<tr>
<td>3. Protect the surrounding skin with a skin barrier cream/spray e.g Cavilon®.</td>
</tr>
<tr>
<td>4. Note when patient last had their bowels opened. Leakage may be due to excessive pressure in the abdomen.</td>
</tr>
<tr>
<td>5. Ensure patient is on an acid suppressing drug to reduce acidity of gastric contents.</td>
</tr>
<tr>
<td>6. For balloon gastrostomy devices, check water volume in the balloon. Note volume of water in the balloon and compare with recommended volume. Replace with recommended volume of water. Leakage may stop if the balloon is inflated a further 2mls.</td>
</tr>
<tr>
<td>7. Dressings can be applied to the gastrostomy stoma when leakage is excessive. Recommend using an absorbent dressing to absorb moisture for example Mepilex dressings (seek advice).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential pain and discomfort following gastrostomy tube insertion or change.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Each patient should receive a strong analgesia immediately post procedure and for the following 24-48 hours depending on patients pain experienced.</td>
</tr>
<tr>
<td>2. Pain assessment should be done regularly throughout the days following gastrostomy tube insertion.</td>
</tr>
<tr>
<td>3. The use of moderate pain relieve is advisable for the first 48 hours post insertion.</td>
</tr>
<tr>
<td>4. After 4-5 days the patient</td>
</tr>
</tbody>
</table>

To reduce patient discomfort and pick up on potential complications.
should only experience mild discomfort from the gastrostomy tube. A patient who is experiencing severe pain needs urgent referral to the doctor or nurse specialist.

5. Following gastostomy tube changes, mild pain relief e.g paracetamol may be helpful.

| Over granulation around the stoma site. | Observe the stoma site daily and ensure the site is cleaned as indicated. If over granulation is noted, ensure the tube is secure and the fixator is snug to the skin. Use an appropriate dressing on the site. Refer to your Physical Healthcare Nurse or Abbott Nurse Advisor regarding type of treatment, which may be helpful. Silver nitrate or 1% hydrocortisone cream may be appropriate which needs to be prescribed by a doctor. Treatment should be continued for 7-10 days. If over granulation persists seek further advice. | Ensuring the gastostomy is secure will prevent tube movement and reduce the incidence of over granulation. Over granulation causes discomfort, infection and bleeding at the site. |

18.1 Diarrhoea

Diarrhoea is a relatively common problem in patients receiving enteral food but is seldom related directly to the feed.

<table>
<thead>
<tr>
<th>Possible Cause</th>
<th>Nursing Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contaminated feed/equipment</td>
<td>Follow microbiological guidelines. Check sterile handling of feed and equipment.</td>
<td></td>
</tr>
<tr>
<td>GI infection e.g. <em>Clostridium difficile</em>, <em>Enteropathic E coli</em></td>
<td>Stool sample. Reduce rate and consult dietarian. Apply isolation precautions.</td>
<td></td>
</tr>
<tr>
<td>Over rapid infusion of feed</td>
<td>Reduce rate and consult dietician</td>
<td></td>
</tr>
<tr>
<td>Pharmaceutical e.g. antibiotics, laxatives, antacids, NSAID’s</td>
<td>Discuss with medical team. Consult Pharmacy and Dieticians</td>
<td></td>
</tr>
<tr>
<td>Feed too cold</td>
<td>Deliver feed at room temperature</td>
<td></td>
</tr>
</tbody>
</table>
### 18.2 Constipation

<table>
<thead>
<tr>
<th>Possible Cause</th>
<th>Nursing Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate fluid</td>
<td>Ensure adequate fluid intake</td>
<td></td>
</tr>
<tr>
<td>Drug therapy</td>
<td>Review drugs</td>
<td></td>
</tr>
<tr>
<td>Disease state</td>
<td>Consider fibre feed or appropriate laxative. Consult Dietician</td>
<td></td>
</tr>
</tbody>
</table>

### 18.3 Nausea or vomiting

| Possible Cause          | Nursing Intervention                                      | Rationale                                                      |
|-------------------------|-----------------------------------------------------------|                                                                |
| Delayed gastric emptying| Consult Dietician and Doctor                             |                                                               |
| Constipation            | See above                                                 |                                                               |
| Drug therapy            | Check drug/nutrient interactions                         |                                                               |
| Too rapid infusion rate | Reduce rate                                               |                                                               |
| Contaminated feed       | Follow microbiological guidelines                        |                                                               |
| Electrolyte imbalance   | Contact Doctor/Dietician, review blood profiles and correct levels |                                                               |

### 18.4 Dry or sore mouth

<table>
<thead>
<tr>
<th>Possible Cause</th>
<th>Nursing Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor mouth care</td>
<td>Good oral hygiene</td>
<td></td>
</tr>
</tbody>
</table>

### 18.5 Abdominal distention

| Possible Cause          | Nursing Intervention                                      | Rationale                                                        |
|-------------------------|-----------------------------------------------------------|                                                                  |
| Delayed gastric emptying| Reconsider choice of feeding route. Try pro-kinetic drugs. |                                                                  |
| Too rapid infusion rate | Reduce rate (consult dietician)                           |                                                                  |
| GI obstruction          | Stop feed                                                 |                                                                  |
| Faecal impaction        | Contact team for assessment to ensure patient is not fully impacted. |                                                                  |
### 18.6 Reflux

<table>
<thead>
<tr>
<th>Possible Cause</th>
<th>Nursing Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too rapid infusion rate</td>
<td>Reduce rate</td>
<td></td>
</tr>
<tr>
<td>Volume too large</td>
<td>Decrease volume of each feed. Consult Dietician</td>
<td></td>
</tr>
<tr>
<td>Poor position</td>
<td>Keep head elevated at 30 degrees minimum while feeding and ½ hour after. (45-90 degrees may be necessary)</td>
<td></td>
</tr>
<tr>
<td>Delayed gastric emptying</td>
<td>Consult Dietician. Reconsider choice of feed</td>
<td></td>
</tr>
<tr>
<td>Decreased GI function</td>
<td>Consult Dietician. Consider drugs to alter gut motility. Assess for decreased bowel sounds, abdominal distension, nausea, vomiting.</td>
<td></td>
</tr>
<tr>
<td>Gastritis</td>
<td>Discuss appropriate medication with team e.g.: H2 receptor antagonist</td>
<td></td>
</tr>
</tbody>
</table>

### 18.7 Blocked Tube

<table>
<thead>
<tr>
<th>Possible Cause</th>
<th>Nursing Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient flushing - not flushing or inadequate flushing of the tube between feeds and before and after medication</td>
<td>Flush with water regularly</td>
<td></td>
</tr>
<tr>
<td>Drug administration</td>
<td>Follow drug administration guide</td>
<td></td>
</tr>
<tr>
<td>Kinked tube / clamp left on</td>
<td>Check tube for obstruction – ensure all clamps are left open</td>
<td></td>
</tr>
<tr>
<td>Back up / curdling gastric contents in gastrostomy tube</td>
<td>Clamp tube between feeds to prevent gastric backflow</td>
<td></td>
</tr>
</tbody>
</table>

**To relieve a blockage:**

*Never use excessive force and never insert objects (e.g. guide-wire) into the tube as this could damage the gastric mucosa.*

- Connect 50ml syringe to the end of tube and try to draw back (aspirate) any excess fluid.
- Flush with warm water (helps dissolve fat globules) and leave for up to 30 minutes. Try to flush again and if unsuccessful, withdraw fluid and repeat.
• Flush with sparkling water; leave the solution in the tube for several minutes, massaging the tube if possible. Repeat above procedure.

• If the tube remains blocked, contact the organisation that inserted the tube, as they will need to replace it.

There are also commercial products to relieve blockages. They are expensive and not always effective.

19. RECORDING AND DOCUMENTATION

Details of the multidisciplinary decision to feed enterally and details of each stage of the procedure must be recorded in the patient’s notes by the appropriately trained practitioners involved.

Feed and water flushes should be recorded on a daily fluid balance chart. Feeds should be signed for on the prescription chart.

20. TRAINING

Only health professionals that can evidence on going competence in insertion of tubes, administration of feed and tube care.

Health professionals that are involved in the care of patients that have enteral feeding require training on the administration of feed. (pump/bolus), stoma/tube care. An annual up date will be required and competencies will be required to be assessed.

21. REFERENCES


HSS08 – Guidelines for Food and Fluid Refusal


Marsden Manual of Clinical Nursing Procedures

Mental Health Act 1983

Mental Health Act 1983 Code of Practice (2008 ed)

Mental Capacity Act 2005

Mental Capacity Act Code of Practice

Deprivation of Liberty Safeguards Code of Practice
# APPENDIX 1

## ENTERAL FEEDING REGIME

### PUMP FEEDING

<table>
<thead>
<tr>
<th>Time</th>
<th>Feed Type</th>
<th>Rate (ml/hr)</th>
<th>Duration of feeding at this rate (hr)</th>
</tr>
</thead>
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**REMEMBER:**

- Ensure patients upper body is elevated at least 30 degrees while feeding and for 1 hour after feed has finished.
- CHANGE THE GIVING SET EVERY 24 HOURS.
- FEED MUST NOT HANG FOR MORE THAN 24 HOURS.

### Special Instructions:

This Regime provides:

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<td>Volume: (ml)</td>
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<td>Fibre: (g)</td>
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Any Problems contact your Dietitian: 0151

**Dietitian:  Signature:**
ENTERAL FEEDING REGIME

BOLUS FEEDING

Name: ___________________________ Hosp. No: ___________________________

D.O.B: __________________________ Date: ___________________________

Consultant: _____________________ Ward: ___________________________

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- Ensure patients upper body is elevated at least 30 degrees while feeding and for 1 hour after feed has finished.
- CHANGE THE GIVING SET EVERY 24 HOURS.
- FEED MUST NOT be kept open FOR MORE THAN 24 HOURS.

Special Instructions:

This Regime provides:

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<thead>
<tr>
<th>Calories: (kcal)</th>
<th>Sodium: (mmol)</th>
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<td>Fat: (g)</td>
<td>Volume: (ml)</td>
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<tr>
<td>Fibre: (g)</td>
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</tr>
</tbody>
</table>

Any Problems contact your dietician: 0151 471 2656

Dietician: ___________________________ Signature: ___________________________
APPENDIX 2

Nasogastric tube position confirmation record

Patient name:  
NHS Number / Hospital Number:  
DOB:  
Ward:

The position of the nasogastric tube should be checked:

- Following initial insertion (please use placement checklist to record this).
- Before administering each feed.
- Before giving medications.
- Any new or unexplained respiratory symptoms or if oxygen saturations decrease.
- At least once daily episodes of vomiting, retching or coughing spasms.
- When there is suggestion of tube displacement.

If you are not able to confirm that the tube is in the stomach it should be removed and reinserted. This should be documented on the nasogastric tube placement bedside checklist.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>pH</th>
<th>External tube length</th>
<th>Checked by:</th>
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</table>

If any new or unexplained respiratory symptoms, contact medical team immediately and stop feed.
APPENDIX 3

Nasogastric feeding bedside chart

Nasogastric tube placement bedside checklist

This bedside checklist should be completed for all patients requiring nasogastric tube placement, on insertion and on all subsequent insertions, before administration of artificial nutrition or medication via the nasogastric tube.

Patient Name:
NHS Number/ Hospital Number:
DOB:
Ward:

Nasogastric tube insertion/ re insertion.

| Date and time of insertion/ re insertion |  |
| NEX measurement |  |
| External length once secured |  |
| Nostril used on insertion/ re insertion L/R |  |
| Aspirate obtain- Y/N |  |
| PH of aspirate (if obtained) |  |
| X- ray required Y/N |  |

Inserted by:

X- ray interpretation (if applicable)

| Date and time of X-ray interpretation |  |
| Is this the most current X-ray Y/N |  |
| Is the X-ray for the correct patient Y/N |  |
| X-ray results eg NG has past level of diaphragm and deviates to left. It is safe to feed via NGT |  |

X-ray interpretation by:
APPENDIX 4

EMERGENCY FEEDING GUIDELINES

When a dietician is not available to prescribe a feed and feeding regimen, the following emergency feeding guidelines may be used. If the patient is at risk of refeeding syndrome according to NICE guidelines, get expert advice before proceeding. As soon as possible the feed and regimen should be reviewed by a dietician since individual needs must be considered.

Proceed carefully if patient is very undernourished and reduce rate if patient is bloated or uncomfortable, or develops diarrhoea.

Pump feeding:

Use a standard 1 kcal/ml feed such as Osmolite. Flush nasogastric tube with 100 ml water before commencing feeding. Flush every 4 hours with 100 ml water. Flush with 30 ml water before and after administration of medication.

**Day 1:** Start feed at 50 ml/hr for 20 hours to give 1 litre of feed (1000 kcal). Allow 4 hours without feeding before recommencing feed.

**Day 2:** If feed is tolerated, increase rate to 75 ml/hr for 20 hours to give 1500 ml of feed (1500 kcal), flushing with 100 ml every 4 hours. Rest for 4 hours.

**Day 3:** If no problems, increase rate to 100 ml/hr and give 1500 ml of feed (1500 kcal) over 15 hours, flushing with 100 ml water every 4 hours. Give an additional flush of 100 ml.

Continue as Day 3 unless otherwise advised.

Bolus feeding:

If a pump is not available, feed may be administered by bolus. Use either standard feed decanted into a suitable container, or cartons of supplementary feeds.

**Day 1:** Aim for approximately 1000 kcal per day, divided into boluses of no more than 150 ml spaced over 14 hours.

**Day 2:** Aim for 1500 kcal per day, divided into boluses of 200 ml spaced over 14 hours.

Store unused portion of feed/supplement in the refrigerator, labelled with the date and patients’ name. Bring to room temperature before administering to patient.
APPENDIX 5

Confirming the correct position of nasogastric feeding tubes in ADULTS

1 Check if on acid inhibiting medication
2 Check for signs of tube displacement and measure tube length
3 Reposition or repass tube if required
4 Aspirate using 50ml syringe and gentle suction

Aspirate not obtained

DO NOT FEED
1 If possible, turn adult onto side
2 Inject 10-20ml air into the tube using syringe
3 Wait for 15-30 minutes
4 Try aspirating again

Aspirate obtained (0.5-1ml)

DO NOT FEED
1 Advance tube by 10-20cm
2 Try aspirating again

Aspirate obtained (0.5-1ml)

DO NOT FEED
1 Leave for up to one hour
2 Try aspirating again

pH 5.5 or below

DO NOT FEED
1 Call for advice
2 Consider replacement/repassing of tube and/or checking position by x-ray

Aspirate not obtained

pH 6 or above

Test on pH strip or paper

pH 6 or above

Aspirate not obtained

pH 5.5 or below

Proceed to feed

CAUTION: If there is ANY query about position and/or the clarity of the colour change on the pH strip, particularly between ranges 5 and 6, then feeding should not commence.

The information in this document was originally developed by the National Nurses Nutrition Group (NNNG) and further developed in collaboration with the Medicines and Healthcare products Regulatory Agency (MHRA), the National Patient Safety Agency (NPSA), NHS clinicians, risk managers and other leading experts in the field. The Patient Safety Research Programme at the University of Birmingham has commissioned additional research to assess these methods further. This advice may therefore be revised following the outcome of this work.
Guideline Summary

Oxford Recommendations - Refeeding syndrome flow chart
See full guidelines for definition and list of at risk patients

Determine level of re-feeding risk (See page 4)
Check baseline potassium, calcium, phosphate and magnesium levels
Replete electrolytes as indicated on page 12

Replete thiamine as per guidelines on page 17

Start feeding at 20 kcal/kg → Moderate Risk
Start feeding at 10kcal/kg → High Risk
Start feeding at 5kcal/kg → Severely High Risk
Do not wait for electrolyte blood level to be within normal range start slow feeding

Send off for further potassium, magnesium, calcium and phosphate levels
6-12hrs after initiation of feeding.

Follow replacement guidelines if electrolyte levels low. If patient more than 2 replacements required, check urinary (24hour collection) magnesium, phosphate and potassium. Inform dietician, to alter feed rate as required.

Monitor potassium, magnesium, phosphate and calcium daily for 1st 3 days or until levels within normal ranges, then 3 times a week for 2 weeks

MONITORING the severely at risk – Restore circulatory volume and monitor fluid balance and overall clinical status closely. Monitor cardiac rhythm continually in these patients and any other who develop cardiac arrhythmias (NICE 2006)
MENTAL CAPACITY, CONSENT & HOSPITAL IN-PATIENT ADMISSION FOR THE ASSESSMENT, CARE and TREATMENT OF ENTERAL FEEDING

FLOW CHART 1.1 Where P is to receive enteral feeding for mental disorder alone

FLOW CHART 1.2 Where P is to receive enteral feeding for an physical disorder unrelated to her/his mental disorder

FLOW CHART 1.3 Where P is to receive enteral feeding for both a mental disorder and a related physical disorder

(Flo. a. The mental disorder is a symptom of or adversely affects the physical disorder
     b. The physical disorder is a symptom of or adversely affects the mental disorder)

FLOW CHART 1.4 Applying the GJ Case and the ‘But For...’ Test

FLOW CHART 1.5 Advance Decisions, Lasting Power of Attorney, Court Appointed Deputy and Court of Protection Decisions

FLOW CHART 1.6 Where P is under 18 years of age and is being considered for hospital in-patient admission, assessment, care & treatment.

The processes are different in circumstances where P is being managed in an establishment that is not a hospital.

IF IN DOUBT AND WHEREVER PRACTICABLE, PRACTITIONERS SHOULD SEEK LEGAL ADVICE PRIOR TO ADMITTING/TREATING P (Normal office hours: The Trust’s legal team; Out of Hours: One of the Trust’s Firms of Solicitors authorised through Bronze On-Call)
FLOW CHART 1.1 Where P is to receive enteral feeding for mental disorder alone

Mental Capacity Assessment

Does P have the mental Capacity to consent to prescribed treatment?

Where P has capacity

P Consents
- Treat as Informal (Voluntary) patient under the authority of s.131 of the MHA1983

P Does Not Consent
- Treatment can only be authorised under the Mental Health Act 1983

Where P lacks capacity to consent

P Does Not Object
- Treat mental disorder under Mental Capacity Act (DoLS may apply). If P has a physical disorder as well then the same rules apply (including DoLS where appropriate)

P Objects
- Treatment can only be authorised under the MHA1983.
FLOW CHART 1.2 Where P is to receive enteral feeding for a physical disorder unrelated to her/his mental disorder

Mental Capacity Assessment

Does P have the mental Capacity to consent to prescribed treatment?

Where P has capacity

P Consents

Decision to treat authorised under common law

P Does Not Consent

Under common law and without exception, P has an absolute right to refuse treatment which cannot be over-ruled

Where P lacks the capacity to consent to treatment of an unrelated physical disorder

The process remains the same IRRESPECTIVE of whether P either objects OR does NOT object to the treatment of the physical disorder. The process is different if P is detained (or is considered detainable) under the MHA1983 for an unrelated mental disorder.

Where P is NOT detained (or is not detainable) under the MHA1983?

Treatment determined under the Mental Capacity Act by applying Best Interest Principles. DoLS may apply here if the full circumstances amount to a deprivation of liberty within the meaning of Article 5(4) of the European Convention on Human Rights

Where P is detained (or is detainable) under the MHA1983?

Treatment determined under the Mental Capacity Act by applying Best Interest Principles. DoLS cannot apply here so an application to the Court of Protection is required if it is considered P is being deprived of her/his liberty
FLOW CHART 1.3  Where P is to receive enteral feeding for both a mental disorder and a related physical disorder

(ie.  
  a. The mental disorder is a symptom of or adversely affects the physical disorder
  b. The physical disorder is a symptom of or adversely affects the mental disorder)

Mental Capacity Assessment

Does P have the Mental Capacity to consent to treatment of the Mental Disorder and the related Physical Disorder?

Where P has capacity

P Consents to:-

- Treatment for Mental Disorder
- Treatment for Physical Disorder

Where P lacks capacity to consent

P Does Not Consent to EITHER treatment of the Mental Disorder AND/OR treatment of the Physical Disorder

P objects to EITHER treatment of the Mental Disorder AND/OR treatment of the Physical Disorder

P does not object to BOTH the treatment of the Mental AND Physical Disorders

APPLY THE ‘BUT FOR...’ TEST
GJ 2009 case law
(See Flow Chart 4 overleaf)

Decision to treat authorised under common law

Where the ‘But For’ Test is NOT satisfied

Where the ‘But For’ Test is satisfied

Treat as Informal (Voluntary) patient under the authority of s.131 of the MHA1983

Treatment cannot be given unless P consents. [P may consent to treatment, and therefore be treated, for one but not the other].

Treatment for both the Mental and Physical Disorders can ONLY be authorised under the MHA1983

Mental Disorder

P cannot be detained under the MHA1983. Therefore, the Mental Disorder CANNOT be treated whilst the ‘But For’ Test remains unsatisfied.

Physical Disorder

Treatment of the Physical Disorder is authorised under the Mental Capacity Act by applying Best Interest Principles. DoLS may apply here if the full circumstances amount to a deprivation of liberty within the meaning of Article 5(4) of the European Convention on Human Rights.
Flow Chart 1.4  *GJ v The FT and The PCT and the Secretary of State for Health [2009] EWHC 2972 (Fam)*

**Applying the GJ Case and the ‘But For...’ Test**

1. **Applying the ‘But For...’ Test**
   - GJ 2009 case law
   - P has a Mental Disorder AND a Physical Disorder
   - P lacks the capacity to make an informed decision re treatment of EITHER the Mental OR the Physical Disorder
   - IF P did not have a physical disorder would s/he need to be detained under the MHA1983?

2. **YES** –
   - Detention under the MHA1983 is necessary for the purpose of hospital in-patient admission, care and treatment of P’s mental disorder ALONE.
   - In-patient admission etc is NOT solely dependent upon any adverse effect that the mental disorder is having upon the physical disorder (or vice versa).
   - Whilst P lacks the capacity to make an informed decision re hospital admission etc, there is clear evidence that s/he objects to this.

3. **NO** –
   - EITHER:
     - There is no appropriate treatment available for managing P’s mental disorder ALONE.
   - In-patient admission etc is necessary BUT is solely dependent upon the adverse effect that the mental disorder is having upon the physical disorder (or vice versa). If you ‘remove’ the physical disorder this dependence is also removed leaving a mental disorder for which there is no appropriate treatment (Therefore, detention under the MHA1983 would be unlawful).
   - AND/OR, there IS appropriate treatment available for the management of P’s mental disorder BUT, although P lacks the capacity to consent, s/he is not objecting to hospital in-patient admission, care and/or treatment of the mental disorder (Bournewod type patient).

4. **Is P’s physical disorder (and/or its treatment) adversely affected by the mental disorder (or vice versa)?**
   - **YES**
     - Treat under the MHA1983
   - **NO**
     - Do NOT use the MHA1983.

5. **Regarding the treatment of BOTH the mental disorder and/or the physical disorder, apply best interest principles under the MCA2005 (using DoLS where appropriate).**
FLOW CHART 1.5 Advance Decisions, Lasting Power of Attorney (LPA), Court Appointed Deputy (CAD) and Court of Protection Decisions

**Advanced Decisions**

- **Mental Disorder**
  - Where P lacks capacity but has made a valid Advanced Decision to refuse hospital admission for the purpose of assessment/care and/or treatment of mental disorder.
  - Authority to Admit can only be given under the MHA1983. If the criteria for detention under the Act cannot be satisfied then P cannot be admitted.
  - If valid Advance Decision includes refusal of treatment for mental disorder THEN this request MUST be complied with UNLESS the treatment is necessary and authorised under Part IV of the MHA1983

- **Physical Disorder unrelated to (or in the absence of) a mental disorder**
  - Any Advance Decision refusing treatment for a physical disorder is binding in law. Treatment cannot be authorised for as long as the Advanced Decision remains valid.

**LPA and CAD Decisions**

- Any Mental Disorder adversely affecting a physical disorder (and/or its treatment) or vice versa.
  - Apply the ‘But For...’ Test (See Flow Chart 4). Advanced Decisions may be over-ruled and ANY necessary treatment authorised under Part IV of the MHA1983 may be given if, and ONLY if, the criteria for MHA1983 detention AND the ‘But For...’ Test are satisfied.

**Court of Protection Decisions**

- If a valid LPA or CAD decision is made to refuse admission to hospital for assessment/treatment of mental disorder THEN P must be assessed for detention under the MHA1983 as if s/he were refusing/objecting to admission.
  - Any and all LPA/CAD decisions to refuse medical treatment are binding in law UNLESS the treatment is authorised under Part IV of the MHA1983.
  - Court of Protection ruling on the administration or withholding of admission/treatment (and/or the use of MHA1983, MCA2005, Deprivation of Liberty Safeguards etc) are binding in law.
  - Where such rulings have been made, practitioners are advised to contact the Trust’s legal team to confirm the parameters of the ruling.
FLOW CHART 1.6 Where P is under 18 years of age and is being considered for hospital in-patient admission, assessment, care & treatment of enteral feeding

**Mental Health Act Code of Practice (2008 ed):**

“36.3 The legal framework governing the admission to hospital and treatment of children is complex, and it is important to remember a number of factors. Those responsible for the care of children and young people in hospital should be familiar with other relevant legislation, including the Children Acts 1989 and 2004, Mental Capacity Act 2005 (MCA), Family Law Reform Act 1969, Human Rights Act 1998 and the United Nations Convention on the Rights of the Child, as well as relevant case law, common law principles and relevant codes of practice.” (p.327)

**Admission and Treatment of Physical Disorders**

The above applies equally to treatment of physical disorders (as with the adult, the Mental Health Act 1983 may apply in circumstances where a mental disorder adversely affects a physical disorder, or its treatment (or vice versa) provided that the GJ ‘But For...’ Test is satisfied (See Flow Chart Pack 1, 1.4).

Different Rules apply for those persons between the age of 16-17 years and those who are under the age of 16 years.

Parental Responsibility may or may not apply dependent upon the circumstances.

Practitioners must, at the very least be fully conversant with Chapter 36 of the MHA1983 Code of Practice and Chapter 12 and the relevant sections in Chapters 8 and 15 of the MCA2005 Code of Practice (as well as the additional legislation highlighted above – see MHA1983 Code of Practice 36.3 above).

**IF IN DOUBT (AND WHEREVER PRACTICABLE):**

PRACTITIONERS SHOULD SEEK LEGAL ADVICE PRIOR TO ADMITTING/TREATING P (Normal office hours: the Trust’s legal team; Out of Hours: One of the Trust’s Firms of Solicitors authorised through Bronze On-Call)
Equality and Human Rights

Mersey Care NHS Trust recognises that all sections of society may experience prejudice and discrimination. This can be true in service delivery and employment. The Trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The Trust believes that all people have a right to be treated with dignity and respect. The Trust is working towards, and is committed to, elimination of unfair and unlawful discriminatory practices. All employees have responsibility for the effective implementation of this policy. They will be made fully aware of this policy and without exception must adhere to its requirements.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998. All public authorities have a legal duty to uphold and promote human rights in everything they do. It is unlawful for a public authority to perform any act which constitutes discrimination.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line with human rights principles of dignity, autonomy, respect, fairness and equality.
Single Equality and Human Rights Screen

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<tr>
<td>Names of people completing screen (Minimum of 3)</td>
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</tr>
<tr>
<td></td>
<td>Collette Irving</td>
</tr>
<tr>
<td></td>
<td>Anna Ashton</td>
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What is the purpose of policy / service change /strategy. what is your this document trying to achieve

These guidelines are intended for use when caring for patients who are not seriously physically ill, but who require enteral feeding. At all times care must be taken to ensure the safety of the patient and staff. These guidelines are informed by NICE Clinical Guideline 32: Nutrition support in adults (February 2006). The NICE guidelines do not specifically cover patients with eating disorders/food refusal, because the aims of intervention differ significantly from those with malnutrition related to physical disease.

The screening of any document is completed to ensure that it does not have either a Direct or Indirect impact on any members from particular protected Equality Groups.
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**Accessibility**

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Other comments noted from the assessment.
Any areas highlighted by the EIA assessors must be put into an action plan. This must record all areas noted even when it can be rectified immediately. The document with the assessment, which includes the action plan, must be available for scrutiny and be able to show:

- What has been highlighted
- What has been done to rectify immediately
- What time frame has been agreed to rectify in the future
HUMAN RIGHTS IMPACT ASSESSMENT

| Right of freedom from inhuman and degrading treatment  
(Article 3) |
<table>
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<tr>
<td><strong>Does this policy ensure people are treated with dignity and respect?</strong>&lt;br&gt;Determined to promote dignity and respect.</td>
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<tr>
<td><strong>Could this policy lead to degrading or inhuman treatment (eg lack of dignity in care, excessive force in restraint)</strong>&lt;br&gt;All decisions to use enteral feeding will be made by the multidisciplinary team in consultation with the patient and their family/carer were possible.</td>
</tr>
<tr>
<td><strong>How could this right be protected?</strong>&lt;br&gt;Enteric feeding will only be used as an intervention as a last resort. Where it is used this should be considered in relation to and in the context of the Mental health Act 1983, The Mental capacity Act 2005, the children’s Act 1989. The policy makes it clear that where the Mental capacity act 2005 is used to authorise enteral feeding the patient should be assessed to see if additional authorisation under the Deprivation of Liberty safeguards apply.</td>
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| Right to life  
(Article 2) |
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<tr>
<td><strong>Does this policy help protect a persons right to life?</strong>&lt;br&gt;The guidelines are not intended for patients who are seriously physically ill however enteral feeding may be used in the following&lt;br&gt;• Food/fluid refusal or hunger strike to preserve life.&lt;br&gt;• Psychiatric disease e.g anorexia nervosa, severe depression.&lt;br&gt;• Neurological problems.&lt;br&gt;• Swallowing disorders.&lt;br&gt;Stroke or head injury.</td>
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<tr>
<td><strong>Does this policy have the potential to result in a persons loss of life?</strong>&lt;br&gt;The human rights act 1998 does not allow for a patient to actively take their own life via refusal of treatment or other means.</td>
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<td><strong>How could this right be protected?</strong></td>
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| Right to a fair trial  
(Article 6) |
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<td><strong>Does this policy threaten the right to a fair trial? (eg no appeals process)</strong></td>
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<tr>
<td><strong>How could this right be protected?</strong></td>
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<tr>
<td>Right to liberty (Article 5)</td>
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<td>Does this policy have the potential to restrict the right to private and family life</td>
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<tr>
<td>How could this right be protected?</td>
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<td>Is it prescribed by law?</td>
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<tbody>
<tr>
<td>Does this policy support a person’s ability to express opinions and share information</td>
</tr>
<tr>
<td>Does this policy interfere with a person’s ability to express opinions and share information?</td>
</tr>
<tr>
<td>Is it in pursuit of legitimate aim?</td>
</tr>
<tr>
<td>Is it prescribed by law?</td>
</tr>
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<td>Is it necessary?</td>
</tr>
<tr>
<td>Is it proportionate?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Right of freedom of religion or belief (Article 9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does this policy support a person’s right to freedom of religion or belief?</td>
</tr>
<tr>
<td>Does this policy interfere with a person’s right to freedom of religion or beliefs? (eg prevention of a person practising their religion)</td>
</tr>
<tr>
<td>Is it in pursuit of legitimate aim?</td>
</tr>
<tr>
<td>Is it prescribed by law?</td>
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<th>Right freedom from discrimination (Article 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have identified an impact, will this discriminate against anyone group in particular?</td>
</tr>
</tbody>
</table>
Is the Document:-

Compliant

Non compliant -
With actions immediately taken

Action Plan completed

Full Impact Assessment Required

Lead Assessor  George Sullivan
Date 09-03-2012