ADDRESS0GRAPH

Enteral Nutrition Standard Orders

These orders are to be used as a guideline to support clinical judgement and professional practice standards. Patient allergy and contraindications must be considered when completing these orders.

■ **Indicates Standard orders. If not in agreement with an order, cross out and initial. □ Requires a check ☑ for activation.**

Allergies (describe): _____

■ **Consult Dietitian** | ■ Height: _____cm ■ Current Weight: _____kg

■ **Pre-EN Bloodwork**

☐ CBC, INR

☐ Na, K, Glucose, BUN, Cr, Corrected Ca, Mg, $P0_4$, Total Protein, Albumin, Pre-Albumin, TG, Total cholesterol, HDL,LDL

Feeding Route

☐ NG/OG ☐ ND/NJ ■ Mark tube at nare/lips and document length of external tube: _____

☐ PEG ☐ J-Tube/PEJ/PEG-J ■ Document brand name and size: _____

■ **Confirm tube placement via X-Ray**

Formula Selection: ☐ Standard Polymeric formula with fibre ☐ Specialty formula ☐ Modular Additives

_____

Method of Administration

☐ Continuous (pump-assisted) Rate:

- ☐ Initial: _____ mL/hr (20-50 mL/hr)
- ☐ Advance by: _____ mL/hr (10-25 mL/hr) Q _____ hour (6-12 hrs) to
- ☐ Goal rate of: _____ mL/hr over ☐ 24 hr or ☐ _____ hr from _____ to _____

☐ Intermittent (gravity-assisted) Rate: **** ONLY per PEG/Gastrostomy tubes AND once feeds well established ****

- ☐ Initial: _____ mL/hour (i.e. 125 mL) for first 2 feeds
- ☐ Advance by: _____ mL (125 mL) every feed to goal of: _____ mL per feed ☐ TID ☐ QID

■ **Fluids/Water Flushes** *(minimum 30 mL Q4H or pre & post feeds ;and minimum 15 ml pre/ post/ in between meds)* ***use tap water (safe drinking water)**

☐ no IV, ☐ _____ mL Q4H or ☐ _____ mL pre & post feeds

☐ IV running, water flush at _____ml Q4H, once TF at goal rate stop IV fluids and provide _____ml Q4H

☐ IV running, water flush at _____ml pre & post feeds, once TF at goal stop IV and provide _____ml pre & post feed

■ **Consult Pharmacy if required**; i.e. for compatibility, challenges and/or if liquid suspension is not available.

■ **Glucose Testing** ☐ **Q a.m.** ☐ **Q4H** ☐ **Q6H** If Glucose greater than 10 mmol/L, initiate Insulin Correction Scale Measures

Prevent Aspiration:

- ■ Head of Bed greater than 30-45 degrees during feed and 30 minutes post feed
- ■ Hold feed for any overt signs of regurgitation or aspiration

Assess Feed Tolerance:

■ Assess for abdominal distention, nausea/vomiting, bowel pattern (i.e. Decreased bowel sounds), abdominal discomfort, blood glucose variations. When two (2) or more of the above are present:

■ Stop TF ■ Inform Prescriber ■ Consult Dietitian

☐ If indicated, assess Gastric Residual Volume (GRV) only when the tube terminates in the stomach. Refer to back page.

Monitoring/Assessment: ■ Intake and Output ■ Weights (daily till stable, then Q Mon) ■ Oral Care per regional policy ■ Bowel movements and bowel sounds every 8 hours and PRN ■ Vital signs daily or Q___H

General Care

■ Verify tube placement every 4 hours ■ Perform site care per guideline ■ Date TF bags and tubing; change every 24 hours

■ Formula hang time less than 8 hours; rinse bag q8h for continuous feeds; rinse post feed for bolus feeds, replace bags q24h

If tube is clogged:

■ Attempt to irrigate with 50 mL warm water using a gentle back and forth motion (Do not use carbonated beverages).

■ Crush 1 tab Pancrealipase (e.g. Cotazyme, VIOKASE, Creon) and 1 tab of sodium bicarbonate (325 mg) or 0.625 ml (1/8 teaspoon) Baking Soda; dissolve in 5 mL warm water. Infuse with 60 mL syringe and let sit for 30 min; then irrigate with warm water. If still occluded, repeat procedure x 1.

■ Notify prescriber if occlusion persists.

Dietitian Signature:	**Date**	**Time**
Approved by Prescriber:	**Date**	**Time**

**** Place copy of Standard Order in the Kardex/MAR ****

Gastric Residual Volume (GRV)

- Do not routinely assess GRV
  - The use of GRV's as a predictor of EN intolerance is controversial and may not be best practice. There is no consensus in the literature to confirm a safe level of GRV. Thresholds range from 120 to 500 ml.
  - GRV's are ONE of several parameters that can be used to monitor the patient's tolerance to EN and should NOT be used in isolation.
- It may be appropriate to check GRV's when:
  - Establishing EN in acutely ill Special care Unit (SCU) patients and as assessed and ordered by prescriber
  - The feeding tube terminates in the stomach. Do not assess GRV's when the tube terminates in the small bowel. This is not a safe practice.
- If ordered by prescriber, check GRV's using the following parameters:
  - Check GRV Q4H for 48 hours,
  - If GRV is less than 200 mL, refeed aspirate, continue TF, recheck GRV in 4 hours,
  - If GRV is greater than 200 mL, but less than 500 mL, refeed aspirate, continue TF and consider starting prokinetic agent; if 2nd GRV is greater than 200 mL after prokinetic agent start, consult MD and/or
  - If GRV is greater than 500 mL, discard aspirate, hold TF and notify the prescriber.

Site Care of the Patient with a Gastrostomy/Jejunostomy

- NOTE: Do not disturb stoma for first 48 hours unless necessary (e.g. excessive drainage, signs of infection, etc.); notify physician if any concerns
  - For the first 48 –72 hours the stoma tract is considered an open wound
- For cleaning and bolster rotation recommendations, refer to the "extended text" tab in Elsevier Feeding Tubes: PEG, Gastrostomy, and Jejunostomy Care – CE