NEW ENTERAL FEEDING POLICY QUICK REFERENCE

Currently, there are varying practices throughout our region. The new policy **promotes consistency** on the care and maintenance of enteral feeding tubes. Doing so **minimizes risks** of adverse events or complications and **improves safety** for the **client** receiving enteral nutrition.

THE NEW POLICY HIGHLIGHTS:

1) **ENTERAL NUTRITION STANDARD ORDERS**
   Scan QR Code below to access CLI.4110.SG.019.FORM.01

2) THE **ENFIT CONNECTOR SYSTEM**
   This is a new industry design standard for enteral feeding that is being phased in for feeding tubes, feeding syringes, and feeding administration sets.

3) **TUBING TYPES AND USES**

   a. *Routine Use:* **Feed Only tubing sets**

   b. *Special Considerations:* **Feed & Flush Administration Sets**
      **used only in special care/critical care units (SCU) dependent on the needs of the individual client*

   c. Tubes meant for **decompression** are not safe to use for TF

   d. **Luer** systems, and **IV** tubing or pumps are not to be used for TF

4) The **INSERTION of an NG** or **SBFT** (stylet and weighted) into the stomach falls *within the nursing scope of practice*.

5) ***INITIAL* TUBE PLACEMENT CONFIRMATION & DOCUMENTATION**
   Tube placement is confirmed by radiology. Documentation should include: type of feeding tube inserted, insertion site, initial external length of feeding tube, internal length per landmarking, and how the procedure was tolerated.

   a. Verifying correct placement is considered a *nursing **safety check**,* which is to be done **Q4H** *or* prior to each use.

6) **TUBE IRRIGATION / FLUSHES**
   This is done using room temperature, potable (safe to drink) tap water per standard orders and as needed.

   a. Flush a **minimum of 30ml Q4H** *or* Pre- and Post-feeds
   **Special pump programming considerations applicable to SCU only.*

   b. Flush a **minimum of 15ml between meds**.

7) **CARE** of ANCHORING DEVICES, TUBING, AND ENFIT CONNECTOR PORTS
   This care differs depending on the type of tube (NG vs. PEG, etc.).

8) MONITORING FOR, AND MANAGING **COMPLICATIONS** AND **TOLERANCE**

   a. *Assess for the following every shift and/or as needed:* Aspiration; Abdominal distension or discomfort; Nausea/emesis; Bowel pattern (decreased or absent bowels sounds); Blood glucose control; Deterioration of hemodynamics or overall status

   b. Gastric Residual Volume (GRV) is assessed only when the tube terminates in the stomach and is indicated. It may be appropriate to check GRV's when:

      i. ordered by an authorized prescriber, using specified parameters as follows:

         1. Check GRV Q4H for 48 hours
         2. If **GRV is <200 mL**: refeed aspirate, continue TF, recheck GRV in 4 hours
         3. If **GRV is >200 mL, but <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
         4. If **GRV is >500 mL**: discard aspirate, hold TF, and notify the prescriber.

Southern Health Santé Sud

QR Code to HPS Resources:

QR Code to ELSEVIER Skills:
user: SH-SS
password: hello

This poster has been created by the **SH-SS Staff Development / Infection Prevention & Control** Team in an effort to prepare healthcare staff for the incoming updated Enteral Nutrition best practice guidelines and policies.