Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Percutaneous Endoscopic Gastrostomy (PEG)/Enteral Tube Care Policy

This procedural document supersedes: PAT/T 16 v.5 – Percutaneous Endoscopic Gastrostomy (PEG)/Enteral Tube Care

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Executive Sponsor(s):	Chief Nurse
Author/reviewer: (this version)	Hannah Stirland, Nutrition Nurse Specialist
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Target audience:	Trust-wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 6	17 March 2021	• Associated IPOC section removed • MCA information updated • Data protection section added • Referral pathway updated • General updates throughout • Appendix 4 included	Hannah Stirland, Nutrition Nurse Specialist
Version 5	8 March 2018	• Updated associated documentation list • Included nutrition nurse specialist responsibilities • Included information on stoma stoppers and PEG grab boxes • Appendix updated	Hannah Stirland, Nutrition Nurse Specialist
Version 4	1 April 2015	• Title change • Covers the full patient pathway from assessment to discharge, including management in the community • Omit Peri-skin PEG Skin Care Policy • Indications for feeding tube updated • MDT responsibilities included • Removed reference to PEG nurse • PEG IPOC WPR numbers included • Associated Trust procedural documents identified • Appendix updated • Contact details updated • References updated	Rebecca Wilkey, Ward Manager S12 Debi Oxley, Senior Sister/ Endoscopy Lead Janet Ryles, McMillan Nurse Head & Neck Mary Peck, Senior Dietitian
Version 3	February 2011	• Title change • Policy combined with the PERI Peg Skin Policy - PAT/T 10 v.3 • Format changed throughout • Guidelines removed from the policy pending implementation of PEG IPOC • Changes of care within IPOC to include: • Patients start feeds at 4 hours, • Clean area with normal saline first 48 hours • Contact details changed with the employment of the PEG Nurse • References updated • Appendix updated and re-designed	Ann Clemitshaw - PEG Nurse Specialist
Version 2	September 2007	• Changed from checking bowel sounds to initiate first feed to checking PH level • If at any time patient complains of pain or if there is any redness or swelling stop the feed added • Wording changed throughout to catheter tip syringes	Ann Clemitshaw - Sister, Endoscopy Debi Oxley – Senior Sister, Endoscopy Carol Bryant - Sister, Endoscopy Vera Todorovic - Consultant Dietitian DR J Sayer -Consultant Gastroenterologist DR R Bolton - Clinical Director, Consultant Gastroenterologist

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1. INTRODUCTION

The aim of this policy is to ensure that all adult patients receive a high standard of evidence-based practice throughout the Trust before, during and following the placement of an enteral feeding tube. This policy excludes naso-gastric and naso-jejunal tubes.

Health professionals must be aware of the type of enteral feeding tube that their patient has in place to ensure that the correct procedures are followed.

The following tubes are useful well-established forms of delivering enteral feed to patients who will require nutrition for a period of one month or more:

- A Percutaneous Endoscopic Gastrostomy (PEG) is a feeding tube which passes through the abdominal wall directly into the stomach. These tubes are designed to stay for a long time

- A Percutaneous Endoscopic Jejenostomy (PEG-J) is a tube that is passed through the PEG tube into the jejenum. This extension tube is narrow and therefore may block easily. If this happens the tube will need to be changed

- A Low-Profile Device (LPD) or Button is a feeding tube which passes through the abdominal wall directly into the stomach which is held in place with a water filled balloon. These devices need changing every 3 months

- A Balloon Gastrostomy Tube (BGT) is a feeding tube which passes through the abdominal wall directly into the stomach and is held in place with a water filled balloon. These tubes need changing every 3 months

- A Jejunostomy (Jej) is a feeding tube inserted through the abdominal wall into the jejunum. These are secured in place in theatre with internal and external sutures

- A Radiologically Inserted Gastrostomy (RIG) is a feeding tube inserted through the skin directly into the stomach under x-ray screening. These are normally removed after 3 months and replaced with another balloon gastrostomy or low profile device

- The Low-Profile Transgastric-Jejunal Feeding Tube is a single unit feeding tube. It enters the stomach through a gastric stoma. The tube is held in place (within the stoma tract) by means of a water filled balloon. These are changed every 3 months.

The decision to initiate long term feeding will involve the patient, carer/family, and members of the multi-disciplinary team including Speech and Language Therapists and Dietitians. The clinical indications for enteral feeding must be reviewed regularly to prevent unnecessary device use.

2. PURPOSE OF POLICY

This policy has been developed to promote the safety of the patient and to unify the processes involved in enteral feeding referral, management and skin care of feeding sites. This will ensure that health workers throughout the Trust are delivering standardised care and management of patients requiring feeding via the aforementioned tubes.

3. DUTIES AND RESPONSIBILITIES

3.1 Responsibilities

The Chief Nurse has overall responsibility for the policy

The Deputy Director of Nursing and patient experience/Deputy Director of nursing and patient safety is responsible for monitoring, implementation and assurance systems.

All clinical service team managers are responsible for ensuring compliance with the policy within their unit/team and that staff are competent in the practice of long term tube management and attend appropriate training.

All Trust employees involved in the practice of enteral feeding are responsible for ensuring they are competent in the procedures used and deliver practice to the policy standards.

Certain professional groups have specific responsibilities:

Dietitians are responsible for:

- Assessment and monitoring the patient's nutritional status
- Advising on the appropriateness for enteral feeding
- Advising on a suitable feeding regime to meet the patient's nutritional requirements
- Monitoring the nutritional status of a patient on enteral feeding and tolerance to the feeding regime and advise of any necessary changes
- Arrange training by the Nutricia nurse for the patient prior to discharge
- Registering patients on Homeward for the supply of equipment/feed on discharge
- To ensure an appropriate handover of dietetic care to the community dietetics provider.

Speech and Language Therapists are responsible for:

- Assessment of patients' eating, drinking and swallowing function and diagnosis of oral, oropharyngeal and pharyngeal swallowing disorders (dysphagia)
- Liaison with the multi-disciplinary team (MDT) regarding the appropriateness of enteral feeding for patients with oral, oropharyngeal or pharyngeal dysphagia
- Monitoring dysphagia while the patient is on an enteral feeding regime, as clinically appropriate. Where necessary, providing information for the MDT with regard to re-instatement of oral feeding

- Assessment and advice regarding the swallowing safety of oral intake/tasters for patients who are enterally fed long term
- Facilitation of communication strategies to assist in capacity assessment for informed consent for patients who have impairment of language/speech/communication as identified by the MDT, family or patient.

Nutrition Nurse Specialist is responsible for:

- Providing training and supporting staff in the aftercare of enteral feeding tubes
- Liaising with Nutricia nurses to provide and integrated approach to patient care
- Advising on the appropriate enteral feeding route when required

Pharmacy is responsible for:

- Providing a medicine information service for staff, patients and carers regarding medicine administration in patients unable to take medicines orally
- Advising on and monitoring the safe, effective and economic use of medicines
- Monitoring for medicine interactions/adverse reactions and whether the therapy is achieving the desired therapeutic end points

Medical/clinical staff are responsible for:

- Monitoring of bloods, urea and electrolytes and correcting any imbalances.
- Treatment of micronutrient and biochemical deficiencies through supplements.
- Management (insertion and on-going care) of feeding devices e.g. PEG feeding tubes.
- Management, recognition and treatment of complications relating to feeding.
- Management, recognition of the manufactures guidelines for individual tube type care
- Ensuring that the enteral (purple) 60ml syringe is used for plunging and gravity feeding medication, flushes and feed
- Ensuring the correct care sheet is used from referral to discharge (there are several available dependent on feeding tube and stage post insertion).

The Nutricia Nursing Service:

- Nutricia Nurses will teach patients and carers on aspects of home enteral feeding to meet their individual requirements.
- The Nutricia Nurses will keep updated of current best practice guidelines.
- The Clinical Governance/Practice Leads will ensure policies are reviewed annually to reflect any changes
- The Nutricia Nurses will work in partnership with other healthcare professionals to share information and expertise thus providing an integrated approach to patient care

The Nutricia Nurses will be guided by and adhere to the professional standards of practice and behaviour for nurses and midwives (NMC, 2015). Nutricia have their own Training Policies and Procedures, which is available for reference from Nutricia Limited. See **Appendix 5** for Nutricia contact details.

3.2 Ethical and Legal Considerations

Nutritional support is not always appropriate. Decisions on withholding or withdrawing nutrition support require a consideration of both ethical and legal principles, both at common law and statute including the Human Rights Act 1998.

When such decisions are being made guidance issued by the General Medical Council (GMC) and the Department of Health should be followed. The decision making process and rationale must be fully documented in the clinical record.

Patients have the right to refuse treatment for various reasons. Refer to the Trust Policy PAT/PA 19 - Mental Capacity Act 2005 Policy including deprivation of liberty safeguards (DoLS) and PAT/EC 1 - Resuscitation Policy.

When such decisions are being made guidance issued by the General Medical Council (GMC) and the Department of health should be followed. The decision making process and rationale must be fully documented in the clinical record.

3.3 Consent

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare. Refer to Trust Policy PAT/PA 2 – Policy for Consent to Examination or Treatment

Prior to referring any patient for PEG/enteral tube placement please refer to Trust guidance on the Mental Capacity Act, and to be aware of any patient with an Advance Decision to Refuse Treatment (ADRT).

3.4 Mental Capacity Act

The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who may not have the capacity to make their own decisions about specific treatments and/or care.

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.

- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.

- Further information can be found in the MCA policy, and the Code of Practice, both available on the intranet.

There is no single definition of Best Interest. Best Interest is determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see Section 5 of the MCA code of practice for further information.

3.5 Record Keeping and Documentation

Clear documentation in the patient's notes is required regarding the reason for placement of long term feeding tube.

The insertion of enteral tubes and any further or subsequent information (e.g. tube changes) must be documented in the clinical records and IPOC (Integrated Pathway of Care).

All feeds must be prescribed on the feeding regime by the Dietitian. **Appendix 1** pump, **Appendix 2** bolus.

Patients awaiting dietetic assessment can be commenced on the out of hours feeding regimen. **Appendix 3**.

Administration of feeds must be signed, on the reverse side of the feeding regimen documentation, by the nurse undertaking the feed.

3.6 Infection Prevention and Control

There are potential hazards associated with enteral feeding which can make it a source for the growth of micro-organisms. Liquid nutrients provide an ideal medium for bacteria and can cause cross contamination to the feeding system during setting up and handling the equipment. Refer to the Trust Policy PAT/IC 19 - Standard Infection Prevention and Control Precautions Policy.

- Decontaminate hands thoroughly using soap and water or alcohol hand gel before and after handling equipment and the preparation process.
- Prepare equipment and opening of feed in a clean environment.
- A no-touch technique should be adopted when preparing the feed during priming and connecting to the administration set/feeding tube.
- Commercially produced, pre-filled ready to hang feeds must be used wherever possible as these are least likely to become contaminated in preparation and use.

3.7 Storage and Care of Feed

All feed packs should be stored in a cool dry place at room temperature, away from direct sunlight. Once opened bottles of feed for bolus feeding should be stored in a refrigerator and

any unused feeds should be discarded after 24 hours. All feeds should be administered at room temperature.

4. INDICATIONS AND REFERRAL

4.1 Indications for Feeding Tube

Feeding tubes are used in adults who are unable to swallow or unable to meet nutritional needs through oral intake alone and need long term artificial feeding. In some cases PEGs/enteral tubes are used to give extra nutrition (or supplements) to people who can still eat.

Feeding tubes may be considered in the following:

- An event which impairs the client's ability to swallow and protect the airway (those at risk of aspiration)
- Dysphagia – assessed by the speech and language therapist
- Loss of appetite that results in significant weight loss
- Diseases of the digestive system
- Increased nutrition needs that cannot be met by eating and drinking alone.
- Anorexia
- Semi consciousness
- Unintentional weight loss greater than 10% within the previous 3 months
- Nasal gastric tube in place for long term feeding
- Head & Neck Surgery
- Neurological conditions.

4.2 Referral for PEG

The multi-disciplinary team should discuss with medical staff the indication for enteral feeding via a PEG tube; this should be documented by medical staff in the patient/clients records.

All PEG referrals must be made on the Trust PEG/RIG Tube Referral and Placement Pathway WPR35454.

The Speech and Language Therapy (SALT) - Section 2 may be completed by the referring team from the advice/assessment and recommendations documented by SALT in the patient's case notes.

The Endoscopy Nurse/ Nutrition Nurse will inform the patient/ward of the planned date.

Some out-patients will require admission to the ward post procedure; this will be assessed by the nutrition nurse specialist on an individual basis.

All patients must have a Methicillin Resistant Staphylococcus Aureus (MRSA) screen and up to date bloods prior to placement.

Early referral to the dietitian is paramount so that a suitable feeding regime can devised if necessary. Outpatients having tubes placed pre-chemo/radiotherapy may not need feeding regimes on placement, therefore an electronic dietitian referral will be completed by the endoscopy department when date for PEG is known.

4.3 Referral for RIG

Patients that have a failed PEG placement or are unable to undergo endoscopic PEG placement eg spinal instability, obstructive dysphagia etc. a RIG can be considered. The referral for RIG should be completed using the PEG/RIG referral booklet WPR 35454, a request for gastrostomy insertion placed on ICE and the nutrition nurse alerted.

X-ray staff are to inform the nutrition nurse specialist that a RIG has been booked or placed to ensure correct procedures and follow-up are arranged.

5. INSERTION AND PROCEDURES

5.1 Procedure for PEG placement

A PEG is inserted in a number of ways but the simplest involves an examination of the stomach with an endoscope passed through the mouth. A PEG feeding tube is then passed into the stomach through a small opening on the wall of the abdomen. Attached to the tube there is a small plastic fixator which lies close to the skin to prevent movement of the tube and a small clamp and Y connector at the end. This requires a minor procedure and is usually done after a sedative injection although some people will require a short general anaesthetic. JEJ and RIG feeding will usually require a radiological or surgical procedure.

GT tubes and LPFD devices can be inserted once the PEG site has fully formed, this may initially need to be done in the endoscopy department but then routine changes can be done in the community by the company Nutricia nurse.

5.2 Care of the long term feeding site

For newly sited feeding tubes follow the IPOCs regarding cleaning and observations. The centimetre marking at skin level must be documented by the nursing staff and escalated to the nutrition nurse or medical team if the tube has moved (see aftercare IPOC for more information).

Gastrostomy exit sites should be cleaned daily as per IPOC. Observe the site for tenderness, irritation, redness or pressure and for the presence of any discharge or leakage. Unless there is a large amount of gastric leakage the site should be left uncovered.

5.3 Early Detection of Complications Post Tube Insertion

All staff need to be aware of the following warning signs that need **urgent** attention:

- Pain on feeding
- Prolonged or severe pain post procedure
- Fresh bleeding
- External leakage of gastric contents.

STOP feed or medication immediately and urgently refer to the team that performed the gastrostomy insertion.

If an established PEG tube falls out or is accidentally pulled out a replacement tube or stoma stopper needs to be inserted straight away. This does not apply to a newly placed PEG/RIG (<4weeks).

A new tube or stopper needs to be inserted as soon as possible as the stoma will start to heal within 2 to 24 hours and/or completely close soon after the tube has come out.

If you have not been trained DO NOT attempt to place a new tube in the stoma obtain a stoma stopper from a PEG grab box/endoscopy and if confident insert into tract.

PEG grab boxes including guidance can be found in the following locations:
DRI – A+E, Ward 16 and 24
BDGH – A+E, ATC, A5
MMH – Rehab 2

- Remain calm
- Place a clean gauze dressing over the stoma to prevent stomach contents leaking onto the skin or clothes
- Obtain PEG grab box from nearest department and follow guidance **see appendix 4**
- Inform the on call doctor and nutrition nurse or to escalate to the endoscopy department/ surgeons.

5.4 Checking the Position of Feeding Tube

On all new or changed feeding tubes checking the measurement is essential to ensure the tube is still in the correct position. Should the feeding tube become dislodged this can potentially lead to life threatening complications.

The following complications can occur post procedure:

- Gastric outlet obstruction
- Buried bumper syndrome (migration of the internal bumper of the PEG tube into the gastric or abdominal wall)
- Dislodged PEG tube

- Peritonitis
- Peristomal leakage or infection
- Skin or gastric ulceration
- Blocked PEG tube
- Tube degradation
- Gastric fistula after removal of the PEG tube
- Granulation around site of insertion of the PEG tube.

On insertion of the PEG tube, the measurement will be recorded on the IPOC. It is vital this is checked every shift and follow IPOC guidelines. Gastrostomy tubes do not require pH testing routinely but measurement should be recoreded.

5.5 Checking the Position of Low Profile Feeding Device and Balloon Gastrostomy Tubes by pH Measurement (including RIG)

Balloon gastrostomy and low profile feeding devices should have confirmation of position using pH prior to first use.

Procedure

- Wash hands
- Remove end cap from the gastrostomy tube (ensure the clamp is closed) attach a 60ml syringe to the tube (open the clamp)
- Very slowly and carefully pull back on the plunger of the syringe until a small amount of fluid (at least 0.5 – 1ml) appears in the syringe
- Close clamp and replace cap
- Place a little fluid on the pH indicator paper
- If the pH value is 5.5 or less the tube is in the correct position
- If the pH value is more than 5.5 do not administer anything via the tube.

Check the pH again in 30 – 60 minutes if the pH remains above 5.5 contact the nutrition nurse specialist or medical staff.

5.6 Management of Tube Feeding

5.6.1 Method of feeding

Feeds can be administered through the use of an electronic feeding pump or using a syringe for bolus feeding. Choosing the right method of feeding is important to maximise tolerance for each individual client.

The two basic methods are:

5.6.1.1 Pump feeding for continuous feeding

The use of a pump allows close control of the rate of delivery of the formula.

- It can be delivered continuously, just overnight or just during the day depending on what suits the patient.
- For those that have an oral intake in conjunction with PEG feeding, it is often useful to use pump feeding overnight to allow them time off PEG feeding and encourage oral intake during the day.
- By slowing the rate of delivery we can improve tolerance for people that may have delayed gastric emptying, reflux and nausea or vomiting. In turn this can reduce aspiration risk.
- Most feeds come in a ready-to-hang pack that connects easily to a feeding pump. This makes it an easy unit for feed administration.

5.6.1.2 Bolus feeding

- Bolus feeding using a syringe is the most common feeding method used. Bolus feeds usually consist of the prescribed feed for one sitting given via a syringe.
- Ideally the syringe should just be held with the plunger removed, allowing gravity to send through the feed.
- However, sometimes a small amount of pressure is needed on the plunger to direct thicker feed in.
- The bolus method provides the client with their requirement of calories daily.
- For most people bolus feeding is the preferred option, however if there are any signs of intolerance e.g. diarrhoea and/or vomiting, then another method of feeding should be sought.

5.7 Discharge

The patient must be informed that if the feeding tube falls out they follow **Appendix 5**.

The Nutricia nurse will come into the wards Monday-Saturday to provide teaching and support to the patient/carer.

All discharge referrals to Nutricia will be made by the dietitian.

The dietitian will require 48 hours notice of discharge to order the feeds required and any equipment needed.

The patient/carer or district nurse will need 14 days of equipment

- 60ml enteral syringes
- Feed
- Feed giving sets (if patient on pump feed)
- Normasol and gauze if new tract

If the patient is on a continuous feed they will need to be discharged with a Flocare Infinity Pump and stand, this will be supplied by the dietitian.

6. TRAINING/ SUPPORT

The training requirements of staff will be identified through a training needs analysis. Role specific education will be delivered by the service lead.

Health professionals must be able to evidence an on-going competence and management in the care of these patients through annual training and updates. All training is documented on OLM.

The trust dysphagia day covers aspects of PEG/RIG feeding and tube management. The nutrition nurse and assistant practitioner are also available to provide training throughout the trust.

7. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Staff competence	Ward Clinical Manager	Monthly	Datix reports. Clinical Governance for Division.
Compliance with policy	Ward /clinical manager	Monthly	Datix reports

8. DEFINITIONS

Aspiration	food or fluid entering of the airway/lungs.
Bolus feed	measured amount of feed and water given by syringe via PEG tube over 15 – 20 minutes. (No faster than 30ml/min).
Continuous feeding	via the PEG over night or throughout the day using a pump.
Feed	liquid nutrition administered by feeding tubes.
Giving set	tubing used for pump feeding that connects the pump to the feeding tube.
Granulation tissue	pinkish red, slightly raised ring of newly growing healthy skin around the stoma.
PEG	Percutaneous Endoscopic Gastrostomy (PEG) is a feeding tube which passes through the abdominal wall directly into the stomach.

Pump	the machine that allows the feed to be pumped through the tube at a set rate.
Reflux	the movement of stomach contents up the oesophagus [food pipe].
RIG	Radiologically Inserted Gastrostomy
Stoma	the opening in the abdomen to the stomach which the feeding tube goes through.

9. EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. **See Appendix 6.**

10. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Standard Infection Prevention and Control Precautions Policy – PAT/IC 19
Mental Capacity Act 2005 - Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) - PAT/PA 19
Privacy and Dignity Policy - PAT/PA 28
Consent to Examination or Treatment Policy – PAT/PA 2
Fair Treatment For All Policy - CORP/EMP 4
Equality Analysis Policy - CORP/EMP 27
Resuscitation Policy - PAT/EC 1
Advance Decision to Refuse Treatment (ADRT) policy – PAT/PA 27
PEG/RIG Tube Referral and Placement Pathway WPR35454.

11. DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

12. REFERENCES

Human Rights Act 1998

NMC (2018) Professional standards of practice and behaviour for nurses and midwives.

National Institute for Health and Clinical Excellence (2017), Nutritional support in adults CG 32.

NPSA/2010/RRR010 Early detection of complications after gastrostomy.

Royal College of Physicians (2010). Oral feeding difficulties and dilemmas. A guide to practical care.

Westaby et al (2010) The provision of a percutaneaously placed enteral tube feeding service, *Gut, 59, 1592-1605* doi:10.1136/gut.2009

APPENDIX 1 – ENTERAL NUTRITION REGIMEN

ENTERAL NUTRITION REGIMEN

Ward: _____

Weight: _____

Height: _____

BMI: _____

Feeding Route: _____

	Estimated requirements	Full regimen provides
Energy (Kcal)		
Protein (g)		
CHO (g)		
Sodium (mmol)		
Potassium (mmol)		
Fluid (ml)		

Checklist:

- If naso gastric tube (NGT), check correct positioning of tube with pH paper before commencing feed
- Check safe positioning of patient (head and shoulders elevated to at least 45° angle)
- Change giving set every 24 hours
- Discard any unused feed after 24 hours
- Flush tube before and after each bottle/feed with _____ sterile water, and before and after administration of any medication

Initial Regimen (to be used on commencing feed) ***N.B. Do not pass a tube or begin feeding without doctor's consent***

Date	Feed type	Volume of feed (ml)	Rate (ml/hr)	Duration of feed (hrs)	Additional Information:

Full Regimen

Date	Feed type	Volume of feed (ml)	Rate (ml/hr)	Duration of feed (hrs)	Additional Information:

Dietitian's Name: _____ Signature: _____ Bleep/ext.: _____

APPENDIX 2 – BOLUS FEEDING REGIMEN

BOLUS FEEDING REGIMEN

Ward: _____

Weight: _____

Height: _____

BMI: _____

	Estimated requirements	Full regimen provides
Energy (Kcal)		
Protein (g)		
CHO (g)		
Sodium (mmol)		
Potassium (mmol)		
Fluid (ml)		

Checklist:

- Check safe positioning of patient (head and shoulders elevated to at least 45° angle).
- Discard any unused feed after 24 hours.
- Flush tube before and after each bottle/feed with ..... sterile water, and before and after administration of any medication.
- For further information see the Trusts "Practical guidance for nutritional support in adults"and "Management of patients following the insertion of a Percutaneous Endoscopic Gastrostomy Tube (PEG)".

Date/Day	Feed type	Volume per bolus	Times	Additional Information:

Dietitian's Name: _____ Signature: _____ Bleep/Ext.: _____

APPENDIX 3 – OUT OF HOURS ENTERAL FEEDING REGIMEN FOR ADULTS

OUT OF HOURS ENTERAL FEEDING REGIME

Checklist:

- If Nasogastric tube, check positioning of tube with pH paper prior to commencing feed (<5.5).
- Check correct positioning of patient (head must be elevated to 45° angle).
- Change giving set every 24 hours.
- Discard any unused feed after 24 hours.
- Flush before and after each feed/medication with 50mls sterile water.
- For more information please refer to trust policy 'Practical guidance for nutrition support in adults'.

Day	Feed	Volume (ml)	Rate (mls/hr)	Duration (hours)	Further information
Day 1	Nutrison Multifibre	300	15	20	4 hours rest Medical team to consider fluids
Day 2	Nutrison Multifibre	500	25	20	4 hours rest Medical team to consider fluids
Day 3	Nutrison Multifibre	700	35	20	4 hours rest Medical team to consider fluids
Day 4	Nutrison Multifibre	1000	50	20	4 hours rest Medical team to consider fluids

Please read the information overleaf if your patient could be at risk of re-feeding syndrome.

Feed can be obtained from:

DRI: Diet bay (Ext 642328),

MMH: Storage room, old therapy room.

BDGH: Catering

☐ **WHEN TUBE HAS BEEN INSERTED AND FEED HAS COMMENCED PLEASE REFER TO DIETITIAN IMMEDIATELY FAX WRITTEN REFERRAL TO 381300 (DRI) or 2809 (BDGH)**

APPENDIX 4 – ACCIDENTAL REMOVAL OF GASTROSTOMY TUBE INCLUDING PEG/RIG AND LOW PROFILE DEVICE

Tube inserted more than 4 weeks?

Yes

Are you trained to re-insert gastrostomy tube?

Yes

Insert new gastrostomy tube ASAP (tract can begin to close within 2 hrs)

Ensure pH 5.5 or below

Request tubogram if clinically indicated

Monitor for or advise patient of red flag warning signs

No

Insert CORSTOP ASAP (see guidance overleaf)

Admit patient to CDU/AMU/ATC

Monitor for signs of peritonitis

Contact: **Nutrition nurse** or **endoscopy** ASAP for replacement tube

No

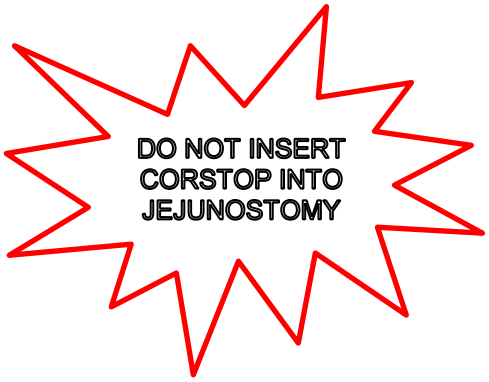
Cover with dry dressing

Do NOT attempt re-insertion

Admit and refer to endoscopy/radiology/surgeons for new tube

Monitor for signs of peritonitis

Contact nutrition nurse or endoscopy sister ASAP



Red flag warning signs: 
IF THERE ARE LEAKS OF FLUID AROUND THE TUBE,
OR PAIN ON FEEDING,
OR NEW BLEEDING
STOP FEED IMMEDIATELY.
AND TELEPHONE 08457623670 if in community

Nutrition Nurse
Mon – Thurs 7am-5pm
07551146774 or bleep 1812

Endoscopy Sister DRI 7

CORSTOP Stoma stopper Guidance – For gastric insertion only

Indications:

- Maintaining stoma tract following accidental removal of gastrostomy tube including PEG/RIG/low profile device
- Must only be used in established stoma tracts of 4 weeks[1] and over

Technique:

- Clean stoma site thoroughly
- Use water soluble lubricant
- Select appropriate size CORSTOP
  (14fr 10cm CORSTOP initially, if any difficulty try 12fr 10cm)
- Insert CORSTOP stem slowly and gently into stoma tract, when fully inserted and disk is flush against the patients skin secure with the dressing provided
- Document procedure and call nutrition nurse/endoscopy sister ASAP

Contra-indications:

- If excessive trauma to site DO NOT insert CORSTOP
- If severely infected site DO NOT insert CORSTOP
  In both cases arrange appropriate review i.e. Endoscopy/gastroenterology/nutrition support team).

*Stoma tract can begin to heal within two hours of tube being removed therefore new gastrostomy tube or CORSTOP must be inserted ASAP

Written in accordance with manufacturer's guidance for CORSTOP stoma stopper (Corpak medsystems) and in accordance with trust PEG policy PAT T 16.

1. Westaby et al (2010) The provision of a percutaneaously placed enteral tube feeding service, *Gut, 59, 1592-1605*

Grab box should include:

Product:	Code:
CORSTOP fr14 Lg100cm x1	450-14100
CORSTOP fr12 Lg100cm x1	450-12100
Gastrostomy tube fr12 x1	52-0512
Gastrostomy tube fr14 x1	52-0514
PEG adaptor repair kit 16fr x2	50-6116
Dressing pack	
ENFIT 50ml syringe	
Lubricating jelly	

Please check box weekly and order replacement equipment when used

Grab boxes can be found in the following areas:
DRI - Ward 16, 24 and ED
BDGH- ED, ATC and B6
MMH – Rehab 1

APPENDIX 5 – ADVICE FOR PATIENTS/CARERS WITH PEG/GASTRO TUBE IN THE COMMUNITY

Advice for Patients/Carers with PEG/Gastro Tube/Low profile device

IF THERE ARE LEAKS OF FLUID
AROUND THE TUBE,
OR PAIN ON FEEDING,
OR NEW BLEEDING
STOP FEED IMMEDIATELY.
AND TELEPHONE
[appropriate 24/7 local service]
FOR URGENT ADVICE

Tube Falls Out Blocked tube	Contact: Mon-Fri 9-5: Nutricia Nurse on 07826877295/07747245091/07881802836 Out of hours Doncaster: Single point of access 01302 566999 Out of hours Bassetlaw: attend A+E
Wound care	Nutricia nurse on: 03457623670
Spare accessories	Nutricia nurse on: 03457623670 Out of hours Doncaster: Single point of access 01302 566999

APPENDIX 6 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	Division/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Percutaneous Endoscopic Gastrostomy (PEG)/Enteral Tube Care Policy PAT/T 16 v.6	Surgery and Emergency Care	Hannah Stirland	Existing Policy	20/01/2021

1) Who is responsible for this policy? Name of Division: Directorate Surgery and Emergency Care

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? The aim of the policy is to ensure that all patients receive a high standard of evidence-based practice throughout the Trust before, during and following the placement of an enteral feeding tube. This policy excludes nasogastric and naso-jejunal tubes. The policy will provide guidance to the multi-disciplinary Team (MDT).

3) Are there any associated objectives? No

4) What factors contribute or detract from achieving intended outcomes? – None

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken] No

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

Date for next review: February 2024

Checked by: Debi Oxley **Date: 23 February 2021**