Tube Feedings

Assessment, Documentation and Changes in Policy
Our population is changing...

The population of patients we serve has gotten older and more medically compromised.
As a result, our nursing skills and policies must adapt to meet the needs of our patients.
Nursing Policy #640.05
“Gastrostomy or Jejunostomy Feeding”

The Nursing Policy for tube feedings has been updated. We have considered best practice and standards of care.

This inservice is designed to provide education about the
• Assessment
• Documentation
• Specific Policy Changes for tube feedings.
Nursing Assessments related to Tube Feedings

- Tube Placement verification – G-tube or J-tube placement must be verified **before each feeding is administered** to assure that the feeding solution is going into the digestive tract.

- Tube Placement also verifies that the tube is patent and not obstructed.

The method of tube placement verification has not changed in the policy.
Nursing Assessments related to Tube Feedings

- Presence of bowel sounds. Bowel sounds should be present in all 4 quadrants of the abdomen.

- Absence of abdominal distention. Abdomen should be soft and without distention.

- Peristomal Skin Condition. Skin should be without excessive redness, swelling, or signs of infection.
Nursing Assessments related to Tube Feedings

• Bowel Movements – Nurses should be monitoring the frequency and consistency of bowel movements to assure that the patient is not experiencing “dumping syndrome” and that elimination is not impaired.
Documentation

Most of the nurse’s documentation related to tube feedings can now be recorded on the “Enteral Feeding Record.”

![Enteral Feeding Record Table](image-url)

*Document any abnormalities in progress notes*
## Enteral Feeding Record

**RICHMOND STATE HOSPITAL**

**Pilot Form (1/13)**

<table>
<thead>
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<th>DATE</th>
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**Type of Feeding**
- □ Bolus
- □ Cont.

**Method of Delivery**
- □ gravity
- □ pump

**Tube Placement Verification**

**Residual Amt.**

**Residual Appearance**

**Formula**

**Feeding Amount**

**Flush Amount**

**Patient Tolerance**
- □ Tolerated Well
- □ Tolerated Well *Problems w/ feeding

**Bowel Sounds Present**
- □ BS Present
- □ BS Not Present, Dr. notified

**Abdominal Distention**
- □ No Abd. Distention
- □ Abd. Distention

**Peristomal Skin Condition**
- □ Not abnormal
- □ Abnormal

**Bowel Movements (# & Character)**
- □ # of BMs:
  - □ Soft & formed
  - □ Abnormal

**NURSE SIGNATURE**

*Document any abnormalities in progress notes*
This flowsheet captures the assessments and data related to the tube feedings so that the nurse does not have to document in the progress notes, *unless assessments are abnormal*.
The Enteral Feeding Record is a 2-sided form on which the nurse can document multiple feedings. It is to be kept in the Treatment Record Notebook in the Med Room.

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<th>Method of Delivery</th>
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*Document any abnormalities in progress notes*
Each column denotes one feeding.

Indicate the date and time of feeding in the top 2 rows.
Indicate type of feeding and method of delivery.
The nurse will initial the space indicating that tube placement was verified.
Note the amount of residual obtained and a brief description of the appearance of the residual.
Indicate the name of the formula.

Indicate the amount of formula instilled via the feeding tube.
Note the amount of fluid used to flush the tubing.
Check the appropriate boxes for the assessments.

Note that if there are any abnormal findings the nurse must complete a progress note in the patient record, and may need to contact the physician.
Indicate the # of bowel movements since the last feeding, or for each shift (if continuous feeding)

Indicate the character of the bowel movements. If not soft & formed, then a progress note should be written to document abnormals.
Other Documentation

- The nurse will need to record the feeding and flush volumes on the I & O record.

- Every patient on tube feedings should have weekly weights completed and recorded on the appropriate form.
Tubing and solution container

- Are changed every 24 hours
- Are rinsed after feedings in the patient bathroom
- Are not taken to the med room so that cross-contamination does not occur
Changes in the Policy

- Feedings should be administered at least 4 hours apart to assure that the feedings are digested and we are not removing residual that has not had time to digest.
Changes in the Policy

- When checking for residual, only withdraw up to 250 ml. of undigested formula.

- If less than 250 ml. of formula is withdrawn, gently infuse it back into the stomach via the tube and begin the feeding.

- If 250 ml. is withdrawn, **DO NOT replace**. Stop feeding and recheck in one hour. If residual is at least 250 ml. the second time, notify physician.
Tube feedings are now an annual competency that Staff Development will verify for all nurses.

Tube feedings are to be performed by a licensed nurse who has received instruction and has demonstrated competence to do this procedure.
You have completed the inservice on
Tube Feeding

Name (Print): ______________________________________
Signature: ______________________________________
       Date: ______________

Print this slide, sign and date it, and send to the Nursing Administration Office to Terry Slayback for credit for this inservice.