Enteral Feeding Policy for Paediatric patients at Macclesfield District General Hospital
**Policy:** Enteral Feeding Policy for Paediatric patients at Macclesfield District General Hospital

### Executive Summary and associated documents:
This policy is aimed at all employees of East Cheshire NHS Trust and staff of other organisations who are working within the trust, who have direct responsibility for the placement and management of enteral feeding tubes and for the administration of enteral feeds in children and young people. The policy also applies to student nurses under the supervision of a registered nurse who is competent in this aspect of care and the supervisory role. The policy covers:
- Nasogastric feeding
- Oro-gastric feeding
- Gastrostomy feeding
- Jejunal feeding

The aim of this policy is to ensure that the insertion and subsequent management of enteral feeding tubes is safe, effective and comfortable for the patient. This policy will set the standards for practice and will reflect the requirements of the National Patient Safety Agency (NPSA) and NICE.

### Supersedes:
Guidelines for the insertion and management of Naso-gastric tubes on the Paediatric unit and Guidelines for the use and management of Gastrostomy tubes on the Paediatric Unit

### Description of Amendment(s):

### This policy will impact on:
Children’s Ward, A&E, Children’s Outpatients, Theatres, Pharmacy, Pathology

### Financial Implications:
Cost implications for consumables and equipment

### Policy Area: Nursing and Dietetics

<table>
<thead>
<tr>
<th>Version Number:</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issued By:</td>
<td>Women &amp; Children’s Service Line</td>
</tr>
<tr>
<td>Authors:</td>
<td>Georgina Timson, Jo Shippey and Malcom Wallace</td>
</tr>
</tbody>
</table>

### Document Reference:

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| Review Date:    | August 2019 |
| Impact Assessment Date: | May 2015 |

## APPROVAL RECORD

<table>
<thead>
<tr>
<th>Committees / Group</th>
<th>Date</th>
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<tbody>
<tr>
<td>Consultation:</td>
<td>March 2015</td>
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<td>17/08/2016</td>
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<tr>
<td>Received for information:</td>
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</tbody>
</table>
1. Policy Statement

This policy is aimed at all employees of East Cheshire NHS Trust and staff of other organisations who are working within the trust, who have direct responsibility for the placement and management of enteral feeding tubes and for the administration of enteral feeds in children and young people. The policy also applies to student nurses under the supervision of a registered nurse who is competent in this aspect of care and the supervisory role. The policy covers:

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- Oro-gastric feeding
- Gastrostomy feeding
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2. Roles and Responsibilities

The Paediatric ward manager has overall responsibility for the provision of nutrition within the Paediatric unit and is accountable to the trust via the Women’s and Children’s Safety Quality and Standards (SQS) committee.

The ward manager and Nursing Sisters are responsible for ensuring compliance with this policy with the paediatric unit/team and that staff are competent in the practice and attend appropriate training.

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

Certain professional groups and departments have specific responsibilities:

Paediatric Medical Staff are responsible for:

- Deciding in liaison with the multi-disciplinary team on the optimal approach to each patient’s nutritional needs and ensure informed consent and documentation.
- Prescribe treatment, taking into consideration factors such as drug nutrient interaction and clinical need
- Treating complications
- The monitoring of biochemical and other laboratory parameters e.g. urea and electrolytes.

Paediatric Nursing Staff are responsible for:

- Assessing and documenting the position and patency of tube
- Maintaining competency in all aspects of enteral feeding
- The safe administration of feeds and medication
- Training and assessing competency of parents and carers for discharge

Ward staff are responsible for:

- Ordering and maintaining stock levels of standard enteral feeding equipment and feeds including, NG tubes, enteral feeding syringes, CE accredited pH strips, tablet crushers, pumps, giving sets and sterile containers. Replacement gastrostomy buttons and extension sets should also be kept in stock for long stay patients.
Dietitians are responsible for:
- Assessment and monitoring the patient’s nutritional status
- Advising on the appropriateness of enteral feeding working with the MDT
- Advising on a suitable feeding regime to meet the patient’s nutritional requirements.
- Monitoring the progress of a patient on enteral feeding and advice of any necessary changes to a patient’s feeding regime
- Arranging for supply of equipment for home feeding

Pharmacy is responsible for:
- Providing a medicine information service for staff, patients and carers and advising on medicine administration for parents 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 result.

Pathology department is responsible for:
- The provision of laboratory test results and advice to support clinicians and other health professionals in optimising the provision of nutrition to patients.

3. Definition of enteral feeding

The term enteral feeding describes the delivery of nutrition into an individual's gastro-intestinal tract via a tube. Examples include nasogastric tubes (NGT), orogastric tubes (OGT) gastrostomy tubes (Percutaneous Endoscopic Gastrostomy PEG) and Jejunostomy tubes (Percutaneous Endoscopic Jejunostomy PEJ) and conversion of a PEG to jejunal feeding (PEG-J).

3.1. Rationale and Assessment

The decision to initiate enteral feeding should involve the patient (if age appropriate) parent/carer and members of the multi-disciplinary team including speech and language therapists and dietitians.

The patient must be assessed for the most suitable route of enteral feeding

The indication and rationale of the route and type of tube will be clearly documented in the patient’s medical notes.

Enteral feeding is a method of ensuring adequate intake of nutrients in patients who for a variety of reasons are unable to use the oral route or who are unable to take sufficient nutrients to maintain growth and development.

NG tube feeding/hydration should be considered initially for children who’s
- Growth/weight gain is faltering
- Clinically dehydrated or at risk of becoming so

Orogastric feeding is considered when a baby or child is needing nasal CPAP or has oropharyngeal abnormalities.
If long term enteral feeding is required, other feeding routes such as PEG should be considered. This would involve discussion with family, MDT and paediatric surgeons at tertiary centres.

On occasions it is appropriate to use a jejunal feeding tube (PEJ), but this would be at the discretion of the Paediatric Surgeons at tertiary centres.

All patients where long term enteral feeding is being considered should be referred to a dietitian on extension 1126.

3.2. Consent

Prior to the insertion of the enteral tube, the procedure and any risks should be explained to the parent/carer and child (dependent on age/capacity) Informed consent should be obtained from them. The patient's consent must be documented in their notes in compliance with Trust policy on consent.

4. Nasogastric Tubes

A Nasogastric tube is a flexible tube that can be inserted trans-nasally into the stomach. It is commonly used for the delivery of feeds, fluids, medication or drainage of gastric contents. NG feeding is the most common method of providing artificial nutritional support/hydration. It is generally the first route of choice in the acute setting.

4.1. Indications

NG tube feeding is suitable for patients who:
- Have faltering growth or poor weight gain
- Clinically dehydrated
- Have a functioning gastrointestinal (GI) tract

4.2. Contra-indication

- anatomical deformity,
- trauma,
- recent oral, nasal or oesophageal surgery
- Severe gastro-oesophageal reflux disease (GORD).

4.3. Types of tubes

All NG tubes must be radio opaque and have length markings in cm along whole length (NPSA 2013)

An assessment of the child’s requirements must be made to determine if there is a need for long or short term feeding.

PVC tubes
- These tubes are for short term use only.
- They should be changed regularly but may stay in situ for up to a month depending on manufacturers guidelines.
- In general, the range of sizes for paediatric use is 6 Fr to 10 Fr.
Fine bore tubes (polyurethane):
  - These tubes are intended for long term use

Check the manufacturer’s instructions for intended duration of use, as different tubes come with different recommendations.

In general, Use a tube size of 6 Fr, 8 Fr or 10 Fr depending on the size of the child and nature of the feed. The tubes come in a range of lengths, usually 75cm or 85cm or 92cm and the length should be selected based on the size of the child.

4.4. Equipment

All equipment used in enteral feeding must comply with:
  - The Medicines Policy for the Safe and Secure Handling of Medicines within East Cheshire NHS Trust Section 4.4.

4.5. Preparing the child and family

Provide the child and family with adequate information on the reasons and need for enteral feeding and the procedure to be performed. The play specialist or nurse should be asked to assist in preparing the child and family by using distraction techniques.

Where possible use a procedure room to pass the tube. If possible/practicable the child should be fasted for approximately 2 hours prior to the procedure.

4.6. Inserting the nasogastric tube

4.6.1. Naso-gastric tubes may be inserted by:
  - A registered health care practitioner (HCP) who has undergone appropriate training and is deemed competent in the skill. (See NMC Code of Professional Conduct).
  - An HCP in training under supervision by a registered, competent HCP
  - A Health Care Assistant who has undergone appropriate training and is deemed competent in the skill, under supervision by a registered, competent HCP
  - In some cases Mature patients and/or parents/carers who have been trained in the skill and are deemed competent.
  - Competency booklets for staff should be completed and a record kept of competency (see appendix 1 and 2)

4.6.2. Procedure:

Prepare the following equipment:
  - the appropriate size and type of tube
  - sterile water to lubricate the tube
  - foil bowl and tissues
  - CE accredited pH strips
  - 20ml syringe to withdraw aspirate from the stomach
  - sterile water to flush the tube clear of aspirate, once correct placement has been confirmed
  - non-sterile gloves
- tape to secure the tube to the child’s skin
- a drink with a straw or a dummy for the child to suck on

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Explain the procedure carefully to the child and parent.</td>
<td>To prepare the child and reduce anxiety and to obtain consent and cooperation.</td>
</tr>
<tr>
<td>2 Wash hands prior to commencement of the procedure and as appropriate during procedure. Wear Non-sterile gloves and apron.</td>
<td>To minimise the risk of cross infection.</td>
</tr>
<tr>
<td>3 Position the child upright either on someone’s knee or supported by at least one pillow. If under 6 months they can be secured in a blanket. Refer to the unit’s policy on ‘safe holding of children for clinical procedures’.</td>
<td>To obtain the best position to facilitate efficient passage of the tube.</td>
</tr>
<tr>
<td>4 Place hydrocolloid dressing on cheek on the side the tube is going to be placed down and cut a piece of tape the same size ready to secure it in place. Check that the nostrils are clear. Ask the child if age appropriate, which nostril they would prefer for tube placement.</td>
<td>To maintain the skin integrity and to facilitate an easy way to secure the tube and prevent displacement.</td>
</tr>
<tr>
<td>5 Wash hands. Prepare the equipment and remove the selected tube from the package, inspect it, and discard if wet or visibly damaged. For fine-bore tube, check guide wire runs freely by removing from tube and re-passing.</td>
<td>To check the tube for visible damage and that it is within the expiry date before it is passed into the stomach. To select the appropriate size tube to minimise nasal trauma and loss of air entry. To check guide wire is running freely to enable it to be removed easily.</td>
</tr>
<tr>
<td>6 Measure the length of tube to be inserted, by measuring from the bridge of the nose to the tip of the ear lobe and from the ear lobe to the xiphisternum. Make a note of this measurement.</td>
<td>It is important that the tube is the correct length, if it is too short it will not reach the stomach, if it is too long it may kink.</td>
</tr>
<tr>
<td>7 Dip the end of the tube in cooled boiled water. Do not use lubrication gel.</td>
<td>This softens the tube and helps it go down more easily.</td>
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<tr>
<td>8 Pass the tube slowly into the child’s nostril, when you feel a slight resistance, angle the tube slightly so that it goes downwards until it reaches the measured point.</td>
<td>To facilitate efficient passage of the tube and obtain correct position.</td>
</tr>
<tr>
<td>9 Older children may like to have a</td>
<td>To help the passage of the tube.</td>
</tr>
<tr>
<td>Step</td>
<td>Instruction</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>8</td>
<td>Drink while the tube is being passed; a baby may suck on a dummy or a bottle.</td>
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<tr>
<td></td>
<td>The child may cough a little as the tube passes the back of the throat. If</td>
</tr>
<tr>
<td></td>
<td>coughing continues or becomes violent and the child becomes pale or blue-</td>
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<tr>
<td></td>
<td>remove the tube immediately. Never force the tube down if you meet any</td>
</tr>
<tr>
<td></td>
<td>resistance stop and retry, seek advice if unable to pass the tube.</td>
</tr>
<tr>
<td>9</td>
<td>It is important to constantly give reassurance to the child.</td>
</tr>
<tr>
<td>10</td>
<td>Once you have reached the measured point hold the tube in place and gently</td>
</tr>
<tr>
<td></td>
<td>aspirate the tube. Test with pH indicator strips, and check reading is 5.5</td>
</tr>
<tr>
<td></td>
<td>or below showing an acid reaction, see flow chart p.7.</td>
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<tr>
<td></td>
<td>Flush the tube with 10-20mls sterile water</td>
</tr>
<tr>
<td></td>
<td>**If uncertain of the position, seek assistance, prior to removing the</td>
</tr>
<tr>
<td></td>
<td>tube and starting again**</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Gently remove the guide wire and discard. Ensure all ports are closed.</td>
</tr>
<tr>
<td>12</td>
<td></td>
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<tr>
<td>13</td>
<td>Secure the tube to the side of the face.</td>
</tr>
<tr>
<td>14</td>
<td>If there is a risk of removal by the child, apply mittens.</td>
</tr>
<tr>
<td>15</td>
<td>Record the procedure, including the date &amp; time, size and type of tube</td>
</tr>
<tr>
<td></td>
<td>used, the length of insertion, the pH result to confirm correct placement.</td>
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<tr>
<td></td>
<td>Record the length of visible tube from the nostril to the end.</td>
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</tbody>
</table>
4.7 Confirming the position of a naso-gastric tube

Correct NG tube position must be confirmed:
- At the time of insertion
- Before each use
- In the event of the child having an episode of:
  - Retching
  - Vomiting
  - Excessive coughing
  - Respiratory distress
- Following a successful attempt to resolve a blocked tube.
- In the event that the tube appears to have been partially dislodged, e.g. when visible tube length has increased. The tube position should be checked 6 hourly, where possible, or at least once per shift during continuous feeds (NNNG, 2004). The feed may need to be stopped to allow time for the stomach to empty and the pH to become acidic. However, this may not be possible in some metabolic patients who quickly become hypoglycaemic if the feed is stopped.

Following the issue of a medical devices alert by the Medicines and Healthcare products Regulatory Agency (MHRA) in June 2004, the use of blue litmus paper is no longer recommended for confirming the position of a naso-gastric tube. (MHRA, 2004).

This evidence was reinforced by an alert published by the National Patient Safety Agency (NPSA) in February 2005. (NPSA, 2005)

Only pH testing strips should be used to confirm gastric placement of the tube (NPSA, 2005):

<table>
<thead>
<tr>
<th>Position</th>
<th>pH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastric position</td>
<td>pH ≤5.5</td>
</tr>
<tr>
<td>Bronchial position</td>
<td>pH 6-8</td>
</tr>
<tr>
<td>Small bowel position</td>
<td>pH 6-8</td>
</tr>
</tbody>
</table>

To check position of the tube, aspirate a small amount of stomach content using a 20ml or 50ml syringe (except in neonates)

Use pH testing strips to confirm correct placement of the tube. Use the colour indicator chart with pH numbers, as supplied with strips. Document details of test on NGT testing chart

4.7.1 Unable to obtain aspirate

If no aspirate can be obtained insert the tube a further few centimetres or change the child’s position and try again. If still unable to aspirate and it is safe to do so offer the child a drink of water and try again.

Consider drug therapy the child is receiving:
- Omeprazole or Ranitidine may affect the pH, although in the majority of cases a pH of less than 5 has been found.
- Domperidone will speed up the process of gastric emptying.
If still unable to confirm position by aspirate, an x-ray may be necessary to confirm placement.

Consult the next level of senior staff and conduct a risk assessment.

Document the actions & decision on NGT care plan. Options: replace/re-position tube, x-ray, continue based on assessment of risk

**Air insufflation with abdominal auscultation is unreliable and SHOULD NOT be used**

If the tube has been advanced through the stomach into the intestine the pH will increase to 6-8 and the aspirate will be bile-stained.
Decision tree for nasogastric tube placement checks in CHILDREN and INFANTS (NOT NEONATES)

- Estimate NEX measurement (Place exit port of tube at tip of nose, extend tube to earlobe, and then to xiphisternum)
- Insert fully radio-opaque nasogastric tube for feeding (follow manufacturer’s instructions for insertion)
- Confirm and document secured NEX measurement
- Aspirate with a syringe using gentle suction

Aspirate obtained?

YES

Try each of these techniques to help gain aspirate:
- If possible, turn child/infant onto left side
- Inject 1-5ml air into the tube using a syringe
- Wait for 15-30 minutes before aspirating again
- Advance or withdraw tube by 1-2cm.
- Give mouth care to patients who are nil by mouth (stimulates gastric secretion of acid)
- Do not use water to flush

Test aspirate on CE marked pH indicator paper for use on human gastric aspirate

pH between 1 and 5.6

PROCEDURE TO FEED or USE TUBE
Record result in notes and subsequently on bedside documentation before each feed/medication/flush.

pH NOT between 1 and 5.6

Aspirate obtained?

YES

Proceed to x-ray; ensure reason for x-ray documented on request form

Competent clinician (with evidence of training) to document confirmation of nasogastric tube position in stomach

NO

DO NOT FEED or USE TUBE
Consider re-siting tube or call for senior advice

A pH of between 1 and 5.6 is reliable confirmation that the tube is not in the lung, however it does not confirm gastric placement as there is a small chance the tube tip may sit in the oesophagus where it carries a higher risk of aspiration. If this is any concern, the patient should proceed to x-ray in order to confirm tube position.

Where pH readings fall between 5 and 6 it is recommended that a second competent person checks the reading or retests.
4.8 Securing a nasogastric tube

- A clear dressing should be placed over the tube along the cheek. This is recommended for the following reasons:
  - Less irritating for the patient as it secures the tube out of their line of sight.
  - Does not interfere with the patient’s eating, by keeping the tube away from the mouth.
  - A child is less likely to pull the tube out as they cannot see it or feel it when they bring their hands up to the mouth area.
  - For patients receiving humidified oxygen (excess moisture makes the nasal tape slip).
- The external part of the tube should be brought to the same side of the face as the insertion nostril and allowed to rest over the ear.
- The dressing should be checked regularly and replaced if dirty or peeling off.

5. Orogastric tubes (OGT)

Reasons for oro-gastric feeding include:
- A baby who has choanal atresia.
- A baby requiring nasal prong continuous positive airway pressure (CPAP).
- A baby whose airway would be compromised if a nasogastric tube was inserted, for example a baby with a craniofacial anomaly.
- Orogastric tubes must be inserted in children with a suspected or confirmed basal skull fracture.

5.1. How to insert an OGT

The technique and precautions taken are the same as those for the passage of a nasogastric tube, except that the tube is passed directly through the mouth. Refer to section on insertion of a nasogastric tube.

The length of the tube must be adjusted appropriately, the measurement being taken from the xiphisternum to the lips.

5.2. Securing an orogastric tube

The tube should, if possible, be secured to the chin using a suitable hypoallergenic tape. Care should be taken not to damage the lips or gums.

It may prove very difficult to secure an orogastric tube, particularly when the baby becomes more active.

6. Documentation

All patients with an NGT or OGT should have a nursing care plan detailing the date the tube was inserted, the type of tube used, the length it was inserted to. Every time the tube is checked it should be recorded that correct placement has been confirmed including the pH reading.
7. Giving feeds via NGT or OGT

See section 12 for full information re. giving feeds via enteral methods

Consider risk assessment if considering use of continuous pump feeding/hydration via a nasogastric tube.

7.1. Risk Assessment for continuous pump feeding via NGT

There are known to be risks associated with tube feeding at any time of the day, namely that the tube could get caught around a child’s neck or that aspiration of feed (where feed goes into the lungs) or vomiting could occur. The risks are higher when constant supervision is not possible / practical. The risks are also higher with nasogastric (NG) than gastrostomy feeding, because the tube can become dislodged more easily.

Wherever possible, continuous pump feeding should be avoided, but it is recognised that there are situations where it is not practically possible to provide adequate nutrition using bolus feeding alone. In these situations, the risks need to be considered and ways of reducing these risks need to be discussed and implemented.

Tick the risk factors as discussed below:

<table>
<thead>
<tr>
<th>Mobility: (is the child active , Able to roll over etc)</th>
<th>YES</th>
<th>NO</th>
<th>Discussed Date</th>
<th>Agreed Action Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility: (is the child active , Able to roll over etc)</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Position</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the child positioned at a minimum of 30° elevated angle head end of cot /bed</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the child supervised by the parents / carer at all times?</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ways of reducing risks of continuous NG tube feeding:

<table>
<thead>
<tr>
<th>Discussed Action</th>
<th>Agreed Action Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>If NG fed, the feeding pump should be positioned at the top end of the cot or bed with the giving set thread through the bars rather than dangling over the top of the cot</td>
<td></td>
</tr>
<tr>
<td>Anti-reflux medication and / or feed thickeners should be administered as prescribed and the prescription should be reviewed regularly</td>
<td></td>
</tr>
<tr>
<td>Comments box for deviations from advice</td>
<td></td>
</tr>
</tbody>
</table>

Signed…………………………………………. (print/sign and date)
8. Gastrostomy tubes – introduction

Many children have a gastrostomy device and professionals caring for these patients need to have a good understanding of the different types of device in use as well as the skills and knowledge to look after the device, the gastrostomy site and to identify problems.

8.1. Reasons for gastrostomy insertion

If a child requires long-term enteral feeding support, i.e. longer than three months, insertion of a gastrostomy feeding tube should be considered. The device may also be necessary for children who require decompression of the stomach, or in children who have non-concordance with drug therapy.

It is important that the child and family have an opportunity to find out from the clinical team which type of device is to be used so that, when they are admitted for the procedure, they are fully aware of what to expect and have a clear idea of what type of device they will have. They must also be made aware of any other procedures that may be carried out at the same time. (DoH 2005)

8.2. Clinical indications

There are a number of indications for gastrostomy feeding. These include:

- Children having high dose chemotherapy regimes, where they will have mucositis and will not tolerate naso-gastric feeds
- Cystic Fibrosis
- Renal disease
- Cerebral Palsy
- Inborn errors of metabolism
- Gastrointestinal problems
- Trauma, e.g. damage from caustic substances
- Abnormalities of the swallowing mechanism

Placement of a gastrostomy will take place at a tertiary Children’s hospital. Children may be discharged to home or attend the ward with a newly formed gastrostomy.

8.3. Types of gastrostomy

A gastrostomy is any artificial device opening into the stomach. This guideline covers both percutaneous endoscopic gastrostomy (“PEG”) and low profile gastrostomy devices (buttons). Information about the types of gastrostomy devices can be found in the gastrostomy booklet (appendix 4).

Usual practice is that when a gastrostomy is first formed, a PEG is placed initially and then a plan will be made by the tertiary centre to replace after a minimum of 3 months with a button device if appropriate and in accordance with parents wishes.

8.3.1. Management of PEG – post placement 0-7 days

- This is the period when there is the most risk of peritonitis
- Initially post-op clean with saline or boiled and cooled tap water until healing has occurred - continue to clean the site daily
- Do not cover stoma with a dressing unless there is excessive leakage
- Ensure stoma is kept dry
- Do not use talcum powder around the stoma
- Do not open the fixator device-if this is too tight it may be released but by a HCP with competency to do so.
- No bathing for the first 3 weeks
- Observe site for redness and offensive discharge as a sign of infection
- Leave clamp closed while tube not in use. Change position of clamp daily and retain in the top third of the tube.

8.3.2. Management of PEG – week 2 onwards

- Clean site daily and dry thoroughly
- Commence to rotate tube 360° daily
  - Wash hands thoroughly prior to rotation
  - Clean external fixation place with gauze and normal saline
  - Open clamp of fixation plate
  - Life tube free of channel in fixation plate and move the plate away from skin
  - Clean stoma and surrounding skin with gauze and normal saline
  - Push tube into stomach for 3-4 cm, and rotate a full 360°
  - Pull tube back gently until resistance is felt
  - Replace the plate a few mm above the stoma
  - Reinsert the tube into the channel of the plate and close the clamp.
  - Check that the tube is not too tight.
- The child can now have showers or sit in a shallow bath, but the stoma should not be submerged in water for another 2 weeks
- The fixator device should not be moved for another 2 weeks unless causing discomfort
- Continue to observe for signs of infection

8.3.3. Long term management of PEG

- Clean site daily and dry thoroughly
- Rotate tube 360° daily
- The child can now bathe and swim normally, ensuring all caps and stoppers are closed –use a waterproof dressing to cover site for swimming
- After 2-4 weeks depending on type of PEG, the fixator device can be opened and the tube advanced into the stomach for 3-4 cm. Rotate tube and withdraw tube to original position. Check markings on tube if appropriate or until one can feel the bumper against the stomach wall. Replace fixation device. This should be done weekly thereafter to prevent ‘buried bumper syndrome’.
- Observe stoma for signs of infection or over-granulation (redness, bleeding, purulent exudates, pain or discomfort, leakage around the tube from the stoma)
- Check end connectors and clamp to ensure they are patent

8.3.4 Management of Low Profile gastrostomy devices (buttons)

As for PEG’s with the exception of:
- There is no fixator device
- Weekly removal of water from the balloon and replace with appropriate volume of fresh cooled boiled water –see manufacturers guidelines
- Manufacturer’s guidelines vary regarding the length of time the button can be in place. Aim for routine time frame of 4 months or before if needed
- Buttons can be replaced by:
  - A registered health care practitioner (HCP) who has undergone appropriate training and is deemed competent in the skill. (See NMC Code of Professional Conduct).
  - An HCP in training under supervision by a registered, competent HCP
  - A Health Care Assistant who has undergone appropriate training and is deemed competent in the skill, under supervision by a registered, competent HCP
  - In some cases Mature patients and/or parents/carers who have been trained in the skill and are deemed competent.
  - Competency booklets for staff should be completed and a record kept of competency (see appendix 1 and 2)

- Extensions sets should be changed fortnightly and should not be left in situ permanently. After each use, clean and stored as per guidelines (section?)
- As the child grows or if there are weight changes, the stoma should be measured to check if a new size is needed.

### 8.4. Maintaining patency

The gastrostomy tube should be flushed with water before and after feeds and medicines (see section 13.7 on administration of medicines via enteral feeding tubes)

Freshly drawn drinking water can be used for flushing gastrostomy tubes. For children under one year the water should be boiled and cooled or in hospital, sterile water may be used. Follow dietitian’s recommendations on minimum flushing volumes and syringe sizes to be used.
How to Flush Your Feeding Tube

Flushing the tube helps to prevent blockage and infections by clearing the tube. It also prolongs the lifespan of the tube. Think of flushing the tube like washing the dishes after a meal. The push - pause action creates turbulence thereby ensuring a thorough cleaning action.

How to Prevent Tube Blockages

**Constant flushing**
- Fluid in the centre moves faster than fluid in contact with the tube walls, reducing cleaning

**‘Push-pause’ flushing**
- Fluid moves in all directions, flowing crossways and lengthways along the tube, increasing cleaning

The ‘push - pause’ technique increases turbulence which reduces the risk of food or drugs sticking to the tube, thus reducing the risk of a blocked tube.

Moderate pressure should be applied with the plunger when flushing feeding tubes.

**Using a 50ml enteral syringe, flush the tube with a minimum of 30mls of cooled, boiled water or as advised by a dietitian.**

- Before and after each bottle of feed
- Before and after administration of each type of medication
- If the tube is disconnected from the feed, such as going to the toilet or for treatment

Leave a column of water in the tube during the rest period. If no feed or medications are being administered the tube should still be flushed at least once daily with cooled, boiled water to avoid blockages.
8.5 Stoma care

The gastrostomy site should be cleaned every day and the site inspected for signs of infection, and formation of granulation tissue in order to detect early signs of infection and prevent skin breakdown.

The site should be clean and dry at all times. Prevent granulation tissue from spreading; use early non-invasive treatment should it occur. The skin should be kept clean and dry. No dressing is required if the skin is intact.

If excoriation of the skin does occur due to leakage of stomach contents from the site, a barrier product such as Cavilon® can be applied to protect the skin and allow healing to take place. It is important to detect the reason for leakage and resolve the problem.

The new gastrostomy should not be immersed in water until the tract is fully healed.

If granulation tissue has formed, early treatment will hopefully prevent the need for surgical removal of the tissue. Seek medical advice for appropriate treatment.

8.6 Changing the gastrostomy button

8.6.1 Procedure for changing the Gastrostomy Button

East Cheshire NHS Trust recommends that to change a balloon gastrostomy button the National Nurses Nutrition Group guidelines (2016) are followed. These can be accessed via the document below.

8.6.2 Removal of Gastrostomy Tubes:

**Planned:** If Multi-disciplinary team decide that the Gastrostomy can be removed because the child can maintain adequate nutrition and fluid without it the procedure would depend on the type of tube.

For PEG tubes, this would need referral to a tertiary centre for removal.

For balloon retained device, follow procedure as if the device was being changed but leave the stoma to heal. A dressing to cover the wound may be needed initially but the stoma should heal within 72 hours.

**Accidental:** On occasions the balloon retainer can fail unexpectedly causing the button to fall out. Gastrostomy stomas can close quickly, so it is important that a new button is placed as soon as possible to prevent this happening. Most patients should have a spare tube with them. It may be necessary to hold the stoma open with something else for example a balloon retained G tube or as a last resort a Foley catheter to prevent complete closure of the stoma. If a Foley catheter is used, this should be taped to the skin to prevent internal migration of the tube and a plan should be made to change the tube to a registered gastrostomy tube as soon as possible.
9. Jejunal Tube

Jejunal feeding should be considered for patients when gastric feeding is not tolerated. These would be sited at a tertiary centre and the initial post surgical care would be advised by them.

Jejunal feeding is administration of enteral feed via a tube that has been placed into the proximal jejunum distal to the ligament of trietz. This can be achieved using the following methods:

Surgical jejunostomy (Surgical JEJ) - insertion of a polyurethane tube through the abdominal wall into the jejunum during laparotomy.

Percutaneous Endoscopic Jejunostomy (PEJ) – insertion of a polyurethane tube through the abdominal wall into the jejunum under endoscopic vision.

Percutaneous Endoscopic Gastrostomy conversion (PEG-J) - a polyurethane tube is passed through the existing gastrostomy tube and pulled through to the jejunum with an endoscope.

Refer to the patient's medical notes for information regarding the insertion procedure.

Placement of a jejunostomy will take place at a tertiary Children's hospital. Children may be discharged to home or attend the ward with a newly formed jejunostomy.

9.1 Feeding via Jejunal Tubes

The tertiary centre will advise feeding regimens for patients with jejunal tubes and advice should be sought from them. The procedures for feeding and equipment use will be the same as for Gastrostomy.

10. Enteral feeding equipment

10.1. Single Use equipment

Most enteral feeding devices are “single use” meaning that they cannot be re-used. These devices will be identified with the following symbol.

East Cheshire NHS Trust Medical Device and Equipment Management Policy (2013) must be followed at all times.

Devices designated for ‘single-use’ must not be reused under any circumstances.

The reuse of ‘single-use’ devices can affect their safety, performance and effectiveness, exposing patients and staff to unnecessary risk.

The reuse of ‘single-use’ devices has legal implications.
Anyone who reproprocesses or reuses a device intended by the manufacturer for use on a single occasion, bears full responsibility for its safety and effectiveness.

Anyone who reproprocesses a single-use device and passes it on to a separate legal entity for use has the same legal obligations under the Medical Devices Regulations as the original manufacturer of the device.

*MEDICAL DEVICES AGENCY SAFETY NOTICE. SINGLE-USE MEDICAL DEVICES: IMPLICATIONS AND CONSEQUENCES OF REUSE. MDA DB2000 (04) AUGUST 2000*

**10.2. SINGLE PATIENT USE EQUIPMENT**

A medical device that may be used for more than one episode on one patient only and that the device may undergo some form of reproprocessing between each use. DB2006 (04) states that reproprocessing is: ‘To make good a device for re-use by any or a combination of the following processes: cleaning, disinfection / decontamination, sterilisation, refurbishment and repackaging’.

Devices marked for single patient use must not be used for more than one patient.

Equipment that is designated single patient use must be reproprocessed and stored as per manufacturer’s and Trust policy and guidelines.

Enteral equipment requiring reproprocessing is very limited and is likely to be an adaptor or extension set for a low profile gastrostomy e.g. MIC-Key button. Refer to CNSG 015 Microbiological Guidelines for Handling of Enteral Feed and Fluids for further guidance.

**10.3. SYRINGES**

Enteral syringes for oral / enteral use should have a purple barrel and be labelled ‘oral / enteral’ use only. **Clear/White syringes should not be used for enteral feeding.** Enteral syringes should only connect to tubes for enteral use and not to tubes for IV use.

The syringes are currently available with different connectors to fit the various enteral feeding tube ports. However by the end of 2016 all feeding tubes and associated equipment including syringes will have a new universal fitting called **ENFIT**. Until then the recommended syringes should have:

- a female luer connector to fit male luer ports on enteral feeding tubes (reverse luer connector combination)

Where the above guidance cannot be applied to an individual patient (e.g. if the patient has a non-standard tube), a risk assessment for the equipment to be used should be undertaken prior to use. Non-standard equipment should be stored separately, clearly labelled, with restricted access. Only staff with specialist knowledge and skills should have access to these devices (NPSA 2007).

All syringes are to be single use only in the hospital setting even if they specify that they are reusable. The syringe must be discarded after the episode of use.
10.4. **Tubes**

All tubes for enteral use must be labelled ‘for enteral use only’ (NPSA 2007).

All tubes for enteral use should only connect to syringes for enteral use, and not to syringes for IV use (NPSA 2007).

All Nasogastric tubes should have clearly defined centimetre markings along the whole length

The patient should be assessed for the correct enteral tube.

10.5. **Adaptors**

Three way taps and syringe tip adaptors should not be used as routine. The correct enteral syringe should be ordered to fit the tube (NPSA 2007). During the transition phase to ENFIT in 2016 there are adaptors available to ensure that all new equipment is compatible with old.

10.6. **Feeding pump**

Pumps are on loan from a Nutrition company as part of a contract. Each ward is allocated a supply of pumps and is responsible for their use and decontamination.

Staff must have received training for the medical device and demonstrate competency in using the device.

The pump and cable must be kept clean whilst in use. When no longer required for a particular patient, the pump must be cleaned thoroughly and returned to the designated storage area. Refer to manufacturer’s pump manual for correct decontamination procedure.

Damage or faults must be reported to medical electronics

10.7. **Recommended equipment design**

Feeding systems ideally should have recessed connectors, additive ports and a minimum number of connectors/extension sets in order to minimise handling and risk of contamination.

The feed should be in sterile, pre-filled nutrient containers (specialist feeds may not be available in this format. Refer to section 12 below for best practice for non-standard feeds.

The feed bottle should be able to be attached to the giving set without touching the areas that are directly in contact with feed in order to minimise the risk of microbial contamination.
10.8. Disposal of equipment

Clinical waste should be disposed of as per East Cheshire NHS Trust Policy on the Management of Healthcare Waste (2008)

11. Management of Feed

11.1. Storage of feed

Opened feeds
- Temp of fridge should be less than 5°C and greater than 0°C.
- Open cans/bottles of feed must be refrigerated.
- Cover with a lid and label with patient’s name, date and time of opening.
- Opened feeds and modular feeds should be stored on the top shelf away from raw food.
- Discard after 24 hours.

Unopened feed
- Store in a cool dry place away from direct sunlight or heat (minimum 8°C, maximum 25°C).

11.2. Preparation of feed

Hands must be decontaminated as per Trust Infection Prevention and Control Good Practices Policy prior to handling of any feeding systems.

Personal Protective equipment must be worn as per the above policy.

Feeds and fluids should be prepared using an Aseptic Non Touch technique (ANTT).

Sterile Ready-to-Hang feeds should be used, unless the patient has been assessed by a dietitian as requiring a specialist feed that will need to be decanted into a sterile reservoir prior to administration.

Use the appropriate size of pre-packed feed for the patient’s requirements.

All equipment should be kept sealed in sterile packaging until immediately prior to assembly.

For specialist feeds that require decanting into a sterile reservoir prior to administration, the bottle or pack must be cleaned with a 70% alcohol wipe prior to use and opened using a sterile bottle opener as recommended by the manufacturer.

Foil tops must not be opened with fingers, thumbs or non-sterile scissors due to the high risk of contamination. Gloves should be worn.
11.2.1. Sterile ready to hang feeds

These are presented in pre-filled nutrient containers. They attach to a giving set and are designed to minimise the risk of microbial contamination.

Sterile ready to hang feeds should be prepared using an Aseptic Non Touch technique (ANTT). Sterile feeds can hang for no more than 24 hours.

The containers must not be topped up.

11.2.2. Sterile decanted feeds

Sterile feeds that require decanting should be prepared using an Aseptic Non Touch technique (ANTT).

A clean working area must be used

Feed must be decanted into a sterile container or single use enteral syringe.

Prior to decanting, the aperture of a bottle or pack should be wiped with a 70% alcohol wipe as contamination can occur during opening.

11.2.3. Powder feeds (non-sterile)

Many components used in powdered formulas are not sterile and may harbour microorganisms. When reconstituting modular feeds the following must apply:

- A clean working area must be used
- Feeds should be prepared using an Aseptic Non Touch technique (ANTT).
- Only use equipment dedicated for enteral feed when decanting, reconstituting or diluting feeds.
- Sterile water must be used for mixing and diluting.
- A set volume of feed should be prepared once; it must not be topped up

12. Administration of enteral feeds – principles

Once a feed is set up, do not top-up further feed into the container of the feeding systems

Do not decant feeds from bottles to bag sets on the ward.

Use a feeding pump when continuous or intermittent enteral feeds are administered.

Do not heat continuous enteral feeds prior to administration.

Feeds should not usually be diluted on the ward. However, sterile water (or boiled, cooled water) should be used when this procedure is necessary and has been agreed with the ward dietician. (DoH 2005)

The integral drug port of the feed administration system needs to be disinfected with an alcohol-impregnated wipe before and after giving drugs. Try to coordinate the administration of drugs into the feeding set with the change of the set.
All 3 year course pre-registration student nurses must have all feeds double checked by a qualified member of the nursing staff prior to administration.

12.1. **Hanging times for feeds**

The hanging time is the total time the opened feed is kept at room temperature.

Storage time in a refrigerator below 5°C is not included in the hanging time.

There should be individual risk assessment and the hanging times reduced if necessary.

<table>
<thead>
<tr>
<th>FEED TYPE</th>
<th>MAXIMUM HANGING TIME</th>
<th>MAXIMUM STORAGE TIME IN REFRIGERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterile, ready-to-use feeds if not decanted</td>
<td>24 hours</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Sterile feeds decanted into a sterile reservoir using aseptic/non-touch technique</td>
<td>4 hours</td>
<td>24 hours</td>
</tr>
<tr>
<td>Non sterile (modular) feeds e.g. reconstituted powders and mixed feeds decanted into a sterile reservoir</td>
<td>4 hours</td>
<td>24 hours</td>
</tr>
</tbody>
</table>

12.2. **How should supplements/feeds be stored and used?**

12.2.1. **Unopened**

Supplements/liquid feeds should be stored in a cool (5-25°C) dry place.

Some, e.g. Paediasure and Paediasure Plus supplements, are more palatable if served chilled from the Ward fridge.

Powders should be stored in a cool dry place

Always check 'best before' date before using.

12.2.2. **Opened**

The following guidelines should be followed:

<table>
<thead>
<tr>
<th></th>
<th>Once opened use within</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediasure</td>
<td>Reseal, keep in fridge and discard after 24 hrs</td>
<td>Record date &amp; time of opening on lid sticker</td>
</tr>
<tr>
<td>Paediasure Plus</td>
<td>When given as a tube feed, 500ml packs can be hung for up to 24 hrs</td>
<td></td>
</tr>
<tr>
<td>Paediasure Peptide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Similac High Energy</td>
<td>200ml bottle - Reseal, keep in fridge and discard after 24 hrs</td>
<td></td>
</tr>
<tr>
<td>Supplement</td>
<td>Instructions</td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Infatrini/Infatrini</td>
<td>60ml bottle – discard any remaining feed after use</td>
<td></td>
</tr>
<tr>
<td>Paeptisorb</td>
<td>When given as a tube feed, maximum hang time is 4 hours if decanted into a feeding reservoir.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any unfinished feed at room temp should be discarded after 2 hours</td>
<td></td>
</tr>
<tr>
<td>Similac Alimentum, Nutramigen 1, Nutramigen 2, Pepti – Junior, Neocate LCP, Neocate Advance</td>
<td>After opening, keep tightly covered, store in dry area and use within 1 month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Record date of opening tin on the lid</td>
<td></td>
</tr>
<tr>
<td>Duocal Powder, Maxijul Powder, Carobel Instant</td>
<td>1 month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Record date of opening tin on the lid</td>
<td></td>
</tr>
</tbody>
</table>

Any supplement not listed please refer to manufacturer's information or ask the dietitian
12.3 Standard Procedure for ordering Special feeds and supplements

Special feeds and nutritional supplements required for in-patients are ordered directly by the ward, and are not stocked by Pharmacy. This means that a small stock of the more commonly used products needs to be kept at all times, for patients who may need it urgently. The stock needs to be checked regularly and orders made via supplies according the pathway below:

Check stock and record stock levels on check list. This should be done on Sunday or Monday morning in readiness for orders to be placed before Tuesday (by 4pm).

Is Stock Sufficient?

Minimum stock level

Abbott Products
1 box (15) Flexitainers (1000ml)
1 box (15) Flexitainers 500ml
1 box (30) Pump Giving Set
1 box (15) Paediasure Ready to Hang 500ml
1 box (15) Paediasure Plus Vanilla Ready to Hang 500ml
1 box (15) Paedisure Peptide Vanilla Ready to Hang 500ml
1 Tray (48) Similac High Energy 200ml
1 box (6) Similac Alimentum (400g)

Non-Abbott Products
6 x Nutramigen 1 400g tin
6 x Nutramigen 2 400g tin
6 x Neocate LCP 400g tin
2 x Instant Carobel 135g box

NB: If the above products are not available/discontinued the dietetic staff will source a suitable alternative.

Is there a child on the ward requiring feeds?

CHECK the name and volume of feed required by any in-patients who are likely to on the ward for 4 days or more and add this to list feeds required for ward stock.

Complete the Paediatric Abbott and Non-Abbott order forms with required amounts of feeds.
Fax form to supplies department by Tuesday at 4pm (for deliveries the following Monday)
For Urgent orders: Call supplies department ext 3094
File copy of the order form in the ordering file with most recent at the top.

When order is received to the ward, check stock received against the order and sign if correct stock received.
If anything is missing or incomplete order received, contact the supplies department on Ext no. 3094

Order form on infonet under procurement – shared documents
13. Giving Feeds

13.1. Procedure for administration of a bolus Naso-gastric tube feed

AIM: Safe administration of a feed to meet the nutritional needs of a child unable to tolerate oral feeding.

EQUIPMENT:
- Syringe (50ml for silk tube or 20ml for others)
- PH Indicator strips
- Cooled boiled water
- Prepared feed
- Tray to work on if available

The child should be included in family meal times if possible. If the child has a dummy then allow him/her to suck it during the feed, this will help them associate sucking with feeding.

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Prepare the child and explain the procedure. Alter the child’s position where appropriate to ensure head and chest are elevated to a minimum 30° angle.</td>
<td>To prepare the child for the feed and obtain consent and co-operation. To reduce the risk of oesophageal reflux.</td>
</tr>
<tr>
<td>2 Wash hands prior to commencement of the procedure and as appropriate throughout. Prepare equipment on a clean surface (a new set of disposable equipment is needed for each feed).</td>
<td>To reduce the risk of cross infection. To prevent having to leave the child whilst setting up the feed.</td>
</tr>
<tr>
<td>3 Attach the syringe to the end of the tube and gently drawing back the plunger until a small amount of fluid from the stomach appears in the syringe. Do not give feed if no aspirate obtained – refer to problem sheet.</td>
<td>To confirm the tube is in the child’s stomach before commencing feed.</td>
</tr>
<tr>
<td>4 Disconnect the syringe and squirt the fluid onto the pH Indicator strips, the strip should show a reading of 5.5 or below. Do not proceed with the feed if no acid reaction is obtained – refer to flow chart on p.7.</td>
<td>To confirm the tube is in the child’s stomach before commencing feed. Never put feed down the tube if no acid reaction is obtained.</td>
</tr>
<tr>
<td>5 Using the barrel of the syringe attach it to the tube and gently pour in 5-10mls of cooled boiled water this should travel down the tube by gravity. If it does not flow down the tube insert the plunger from the syringe over the opening and apply gentle pressure until flow starts.</td>
<td>To check tube is not blocked.</td>
</tr>
<tr>
<td>6 Once water is moving down the tube follow it with the prepared feed.</td>
<td>To regulate the feed and prevent vomiting or diarrhoea i.e. the higher</td>
</tr>
</tbody>
</table>
feed should travel down the tube by gravity. The feed time should be about as long as a bottle feed would take i.e. approx. 20 mins. the syringe the faster the flow, the lower it is held the slower it will go in.

<table>
<thead>
<tr>
<th>7</th>
<th>Observe child for any signs of abdominal discomfort, throughout the procedure. Ensure there are no signs of respiratory distress. Stop feed if any concerns.</th>
<th>To ensure feed is tolerated. To confirm the feed is going into the child’s stomach</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>When the feed is complete, flush the tube with 5-10mls of cooled boiled water and replace the end-cap.</td>
<td>To prevent milk blocking the tube.</td>
</tr>
<tr>
<td>9</td>
<td>Refasten the tube and place it securely.</td>
<td>To prevent the tube being removed accidentally.</td>
</tr>
<tr>
<td>10</td>
<td>Dispose of non re-usable equipment into a plastic bag that can be sealed.</td>
<td>To prevent cross infection and contamination</td>
</tr>
<tr>
<td>11</td>
<td>Record the procedure and report any changes or problems to parents or appropriate nursing staff i.e. vomiting or loss of feed.</td>
<td>To maintain the child’s well being and safety at all times.</td>
</tr>
</tbody>
</table>

13.2. **Procedure for administration of a continuous Naso-gastric tube feed**

AIM: Safe administration of a feed to meet the nutritional needs of a child unable to tolerate oral feeding.

**EQUIPMENT:**
- Prepared feed
- Cooled boiled water
- Syringe (50ml)
- PH Indicator strips
- Giving set and container
- Feeding pump

If at any time the tube becomes dislodged or the child has breathing difficulty STOP the feed immediately. If appropriate remove the tube by squeezing it and removing it from the nostrils.

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Prepare the child and explain the procedure. The child should be placed in comfortable position with head and chest elevated to a minimum 30°angle.</td>
<td>1 To prepare the child for the feed and obtain consent and co-operation. To reduce risk of oesophageal aspiration.</td>
</tr>
<tr>
<td>2 Wash hands prior to commencement of procedure and as appropriate throughout. Prepare the equipment (a new set of disposable equipment is required for</td>
<td>2 To reduce the risk of cross infection. To prevent having to leave the child whilst setting up the feed.</td>
</tr>
<tr>
<td>Step</td>
<td>Task</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>each feed) on a tray and check the pump is working.</td>
</tr>
<tr>
<td>2</td>
<td>Run the prepared feed through the pump as instructed by the manufacturer.</td>
</tr>
<tr>
<td>3</td>
<td>Attach the 50ml syringe to the nasogastric tube and check it is in position by aspirating a small amount of stomach contents onto the pH Indicator strips, which should show a reading of 5.5 or below.</td>
</tr>
<tr>
<td>4</td>
<td>Flush the tube with minimum 5ml cooled boiled water</td>
</tr>
<tr>
<td>5</td>
<td>Connect the tip of the feed extension to the tube. (Select the most appropriate end, according to fit)</td>
</tr>
<tr>
<td>6</td>
<td>Turn the machine on and set the rate according the care plan. Stay with the child for a short time to ensure that the feed is running smoothly.</td>
</tr>
<tr>
<td>7</td>
<td>Monitor at intervals to check correct amount is being delivered and that ends remain connected. Listen for alarms.</td>
</tr>
<tr>
<td>8</td>
<td>Check the child is tolerating the feed and is not experiencing any problems e.g. vomiting breathing difficulty etc.</td>
</tr>
<tr>
<td>9</td>
<td>When the feed is completed. Wash hands, turn machine off, clamp tube and disconnect ends. Flush tube with 10mls of cooled boiled water. Cap the tube and secure it out of the child’s reach.</td>
</tr>
<tr>
<td>10</td>
<td>Empty any unused contents down the sink and dispose of any non re-usable equipment into a plastic bag that can be sealed and put into the domestic bin.</td>
</tr>
<tr>
<td>11</td>
<td>Record the procedure and report any changes or problems i.e. vomiting or loss of feed to parents or nursing staff</td>
</tr>
</tbody>
</table>
13.3. **Procedure for administration of a Gastrostomy bolus feed using a syringe**

**AIM:** Safe administration of a feed to meet the nutritional needs of a child unable to tolerate oral feeding.

**EQUIPMENT:**
- Syringe 50ml
- Feed at room temperature
- Cooled boiled water (for flushing tube)
- Clean empty container
- Appropriate extension set (if a button is being used, see section 14.6)

Procedure:

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Prepare the child and explain the procedure.</td>
</tr>
<tr>
<td>2</td>
<td>Wash hands prior to commencement of the procedure and as appropriate throughout. Prepare equipment on a clean surface (a new set of disposable equipment is needed for each feed).</td>
</tr>
<tr>
<td>3</td>
<td>Check the feed is correct according to dietitian’s recommendations, that the bottle is in date and not damaged.</td>
</tr>
<tr>
<td>4</td>
<td>Attach the syringe to the gastrostomy tube or extension set. Flush the Gastrostomy tube/button extension using a minimum of 5-10mls of cooled boiled water from a clean container. Clamp the tube or extension set with water in situ</td>
</tr>
<tr>
<td>6</td>
<td>Keep the syringe attached to the gastrostomy tube or extension set and start to administer the feed. Tube feeds should be given over at least 15-20 minutes (Children would not normally take feeds any faster than this if they were feeding orally.) The speed of delivery under gravity can be altered by increasing or decreasing the height of the syringe compared to the tube, do not use the plunger unless advised</td>
</tr>
<tr>
<td>7</td>
<td>Observe child for any signs of abdominal discomfort, throughout the procedure.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>8</td>
<td>When the feed is complete, flush the tube with 5-10mls of cooled boiled water and replace the end-cap of the gastrostomy or remove the extension set.</td>
</tr>
<tr>
<td>10</td>
<td>Dispose of non-re-usable equipment into a plastic bag that can be sealed. Clean extension set according to guidelines in section 14.6. Keep any unused feed in the fridge until the next feed or until it is open for the maximum time allowed, whichever is the soonest. (see section 13.1)</td>
</tr>
<tr>
<td>11</td>
<td>Record the procedure and report any changes or problems to parents or appropriate nursing staff i.e. vomiting or loss of feed.</td>
</tr>
</tbody>
</table>

13.4. **Procedure for administration of a Gastrostomy feed using a pump**

AIM: Safe administration of a feed to meet the nutritional needs of a child unable to tolerate oral feeding.

EQUIPMENT:
- Syringe 50ml
- Feed at room temperature
- Cooled boiled water (for flushing tube)
- Feeding pump
- Giving set (change every 24 hours)

Procedure:

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Prepare the child and explain the procedure.</td>
</tr>
<tr>
<td>2</td>
<td>Wash hands prior to commencement of the procedure and as appropriate throughout. Prepare equipment on a clean surface (a new set of disposable equipment is needed for each feed).</td>
</tr>
<tr>
<td>3</td>
<td>Check the feed is correct according to dietitian’s recommendations, that the bottle is in date and not damaged.</td>
</tr>
<tr>
<td>Step</td>
<td>Instructions</td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
</tr>
<tr>
<td>1</td>
<td>Connect the feed bottle or container to the giving set, using a ‘non touch technique’. Prime (run the feed through) the tubing. Some pumps have ‘autoprime’ functions – please refer to the pump manual. Place the feeding set in the pump. Set the pump including the feed rate and dose if appropriate according to feed prescription and pump guidelines (see manual).</td>
</tr>
<tr>
<td>4</td>
<td>Attach a syringe to the gastrostomy tube or extension set. Flush the Gastrostomy tube/button extension using a minimum of 5-10mls of cooled boiled water from a clean container. Clamp the tube or extension set with water in situ.</td>
</tr>
<tr>
<td>5</td>
<td>Connect the giving set to the gastrostomy tube or extension set. Open the clamp on the Gastrostomy tube or extension set and turn the pump to ‘run’.</td>
</tr>
<tr>
<td>6</td>
<td>Observe child for any signs of abdominal discomfort, throughout the procedure.</td>
</tr>
<tr>
<td>7</td>
<td>When the feed is complete, clamp gastrostomy tube or extension set and disconnect giving set. Flush the tube with 5-10mls of cooled boiled water and replace the end-cap of the gastrostomy or remove the extension set.</td>
</tr>
<tr>
<td>8</td>
<td>If doing intermittent feeds, cap off the giving set (this maintains a closed system), and leave at room temperature or if your child is under 1 year, change the giving set for each feed. Discard any unused feed after 24 hours. Dispose of non re-usable equipment into a plastic bag that can be sealed.</td>
</tr>
</tbody>
</table>
Clean extension set according to guidelines in section 14.6

| 9 | Record the procedure and report any changes or problems to parents or appropriate nursing staff i.e. vomiting or loss of feed. | To maintain the child’s well being and safety at all times. |

13.5. **To relieve wind**

If the child appears to experience a lot of abdominal discomfort (colic) after feeding and they find it difficult to get rid of wind, a 50ml catheter tip syringe can be attached to the Gastrostomy or extension tubing prior to feeding, if this is held above the level of the stomach air may then be released.

13.6. **Button devices: attaching the extension set**

Attach the extension set to the feed port ensuring the locking mechanism is secure.

To attach the set:
- Lift up the safety cap from the feeding port.
- Line up the black line on the extension set with the black line on top of the button.
- Push the extension set into the feeding port, whilst gripping the external stabilizer to prevent putting undue pressure on the child’s abdomen.
- Turn the extension set clockwise until it stops, but do not over tighten as this can damage the non-return valve of the button itself.

The extension set is now locked in place and ready for use.

After use disconnect and wash the extension set under running water and syringe it through with a mild detergent solution. Follow this with a thorough rinse with cold water. Allow the extension set to dry.

A luer-lock extension set is particularly useful for overnight feed administration.

13.7. **Administration of medicines via enteral feeding tubes**

There are a number of considerations when using enteral feeding tubes to administer medicines. These include:

- Problems with blocking the tube
- Interactions with the feed
- Alteration in the absorption of medicines
- Drugs may not be available in a form which can be administered via some fine bore tubes
- Some drugs may interact with the nutrients in the feed, which could lead to increased absorption, changes in gut motility or decreased absorption
- If the tube is in the jejunum, absorption may be affected.

It is important to inform the pharmacist when drugs are to be administered via enteral feeding tubes, and to provide him/her with details of the type of feed the child has
been prescribed. Drugs are not usually licensed for administration via enteral feeding tubes. However this may be the only option for some patients.

Where possible, liquid preparations should be used but soluble, dispersible and crushed tablets and the extracted contents of capsules can be used. However, the contents of some capsules are enteric coated and may not disperse, or the granules may need a solution other than water to disperse them, e.g. Omeprazole.

Some liquid preparations may need further dilution if they are very thick. However, advice should be sought from the pharmacist. If the medicine is available only in tablet form, the pharmacist will advise if it can be crushed and mixed with sterile water for administration. Enteric-coated drugs should not be crushed as they may be designed for absorption from the jejunum or the coating may be designed to protect the stomach from the drug.

If sub-lingual preparations are given via the enteral route this could result in under-medication of the child as these drugs are designed to avoid the gastro-intestinal route, and the sub-lingual dose is usually lower than the oral preparation.

If crushing cytotoxic drugs for administration via an enteral feeding tube, follow the instructions in the policy on Administration of Chemotherapy and the East Cheshire NHS Medicines policy.

Drugs containing sorbitol may cause diarrhoea, therefore the patient should be observed for changes in stool output.

Remember to consider infection due to contamination of feeds, though this rarely occurs provided that the guidance contained in this document is followed. Drugs should not be added to enteral feed preparations. Medicines to be administered orally or enterally should not be drawn up in IV syringes.

13.7.1. Method of giving medication via enteral feeding tubes

If tube is NGT or OGT test the position of the tube

Flush the tube after testing position and following administration of the drug. If more than one drug is to be administered, flush the tube between each drug with 3-5mls of water. Document the amount of flush administered in the child’s fluid balance chart.

Follow pharmacy guidelines on timing of administration of drugs. For example, phenytoin absorption is affected by the presence of enteral feed. Therefore, continuous feed should be stopped for a period of at least 2 hours before and after feed.
14. Blocked enteral feeding tube

<table>
<thead>
<tr>
<th>BLOCKED NASOGASTRIC, GASTROSTOMY AND JEJUNOSTOMY TUBES PROBLEM</th>
<th>POSSIBLE CAUSES</th>
<th>INTERVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tube blockage</td>
<td>Not flushing or inadequate flushing after feed and medication.</td>
<td>Flush as per guidelines. Refer to CNSG 013 Guidelines for Administration of Feed and Fluid via Enteral Tubes for more information regarding best practice for</td>
</tr>
<tr>
<td></td>
<td>Multiple medications being given together without a flush in between each drug.</td>
<td>Administer medication as per CNSG 016 Guidelines for Administration of Medications via an Enteral Feeding Tube.</td>
</tr>
<tr>
<td></td>
<td>Unsuitable medicine preparations for giving via a tube, e.g. large particles, viscous liquids.</td>
<td>Review medication and consider alternative medication. If NG tube or gastrostomy balloon tube, consider a larger bore tube.</td>
</tr>
<tr>
<td></td>
<td>Kinked tube/clamp left on (PEG only).</td>
<td>Release clamp/straighten tube. NG tube may be kinked in the stomach, pull back slightly and retry.</td>
</tr>
<tr>
<td></td>
<td>Backflow/curdling of gastric contents in the tube.</td>
<td>Clamp tube (if PEG) between use to prevent gastric backflow. Leave a column of water in the tube after flushing.</td>
</tr>
<tr>
<td></td>
<td>PEG bumper buried in the gastric mucosa (‘buried bumper syndrome’). Commonly presents with the tube becoming increasingly difficult to flush and increased leakage around the PEG site, particularly during flushing.</td>
<td>This can be prevented by weekly pushing the tube into the stomach a couple of centimetres and rotating Refer CNSG 009 Guidelines for Insertion and Management of Gastrostomy Tubes, section 7.6.5. The patient will need to be referred to the gastroenterologist for tube removal/replacement.</td>
</tr>
</tbody>
</table>

14.1. Guidelines for unblocking the tube

- Flushing with water can remove most blockages.
- Use a 60ml oral/enteral syringe with a plunger
- Prime with 20-30mls warm water
- Flush by using a pumping action
- Squeeze along the tube using thumb and forefinger, and then retry flushing.
- Once cleared, flush thoroughly.
(Colagiovanni 2000)

If unsuccessful:

Try using a smaller syringe, 20mls then 10mls then 5mls. Caution. This will exert greater pressure and may split the tube. Check the tube for leakage after the blockage has been cleared.

Using Coca cola/ pineapple juice: Anecdotal evidence suggests that this can be useful as a one off, however long-term use may damage the tube.

14.2. Over-granulation

If over granulation occurs please refer to section 8.5.

14.3. Changing size of button

Practitioners should be aware that at the patient grows, gains or loses weight, a different sized gastrostomy tube may be required. There are measuring devices in place to aid this which can be obtained from the dietetics department.

15. Discharge planning

If the child is commenced on enteral feeding whilst he/she is an inpatient at MDGH and other Tertiary centres and it is envisaged that this method of feeding will continue following discharge, discharge planning should commence at the earliest opportunity.

- Contact with the community children’s nursing team is essential when planning the discharge of children who require medicines to be administered via enteral feeding tubes.
- All patients for consideration of NG feeding should be referred to a dietician. This may not be possible if the decision to feed is made out of hours. In this case the dietetic referral should be phoned through to the dietetic answer machine Ext 1126.
- Parents/carers should be assessed for their competency of using NGT and what to do if they have any problems.
- Patients need to be discharged with a minimum of 7 days supply of feed and equipment from the ward supply and a complete discharge check list (see Guidelines for parents and carers of children requiring Gastrostomy feeding or Nasogastric feeding in the appendices)

16. Training

- Medical and nursing staff involved in the management of enteral feeding tubes must be competent in procedures and care processes relating to enteral tube care and aware of potential risks to the patient.
- Prior to independent practice, Trust staff will undertake training and supervised practice which will include the completion of a Trust workbook and competency assessment relevant to the type of tube that the patient has in situ e.g. nasogastric, nasojejunal, gastrostomy, jejunostomy.
• It is the responsibility of individual health professionals to maintain and update their knowledge, skills and competencies in the management of enteral tube feeding and keep their own record of continuing professional development.

17. Monitoring

Whilst on the ward for patients with existing gastrostomies, staff will monitor for signs of infection at the site and patency. Any concerns will be escalated to the CCNT initially and/or medical staff and referred to TV where appropriate.

If a patient is long term on the ward and gaining weight, staff need to be mindful that the size of their button may change and staff should look for signs that the button is too loose or too tight. Measuring devices are available from dietetics. This is the same for both acute and community staff.

Patients with NGT or PEG in the community will be monitored for growth and nutritional intake and feed tolerance. 1-6 monthly depending on their clinical need by the Paediatric Dietician.

18. Appendices & Links

• Online link to CORFLO parent/care information booklet
  o [http://corpakmedsystemsuk.com/PDFs/UK%20peg%20information%20booklet.pdf](http://corpakmedsystemsuk.com/PDFs/UK%20peg%20information%20booklet.pdf)

• Online link to Post insertion care of the CORFLO PEG

• Online link to Nutricare-SAF™

• Online link to Care of Mic-Key Button
  o Downloadable from [http://www.mic-key.com/products/mic_key_low_profile.aspx](http://www.mic-key.com/products/mic_key_low_profile.aspx)

• Online link to Care of mini compact balloon button
Equality Analysis (Impact assessment)

Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services.

Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

<table>
<thead>
<tr>
<th>Enteral Feeding Policy for Paediatric patients at Macclesfield District General Hospital</th>
</tr>
</thead>
</table>

Details of person responsible for completing the assessment:

- Name: Malcolm Wallace
- Job Title: Charge Nurse
- Team: Children’s Ward

State main purpose or aim of the policy, procedure, proposal, strategy or service:

(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

This policy is aimed at all employees of East Cheshire NHS Trust and staff of other organisations who are working within the trust, who have direct responsibility for the placement and management of enteral feeding tubes and for the administration of enteral feeds in children and young people. The policy also applies to student nurses under the supervision of a registered nurse who is competent in this aspect of care and the supervisory role. The policy covers:

- Nasogastric feeding
- Oro-gastric feeding
- Gastrostomy feeding
- Jejunal feeding

The aim of this policy is to ensure that the insertion and subsequent management of enteral feeding tubes is safe, effective and comfortable for the patient. This policy will set the standards for practice and will reflect the requirements of the National Patient Safety Agency (NPSA) and NICE

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

Age: East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).
Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

Race:
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
- 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.

Gender: In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

Disability:
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at 18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (The Lesbian & Gay Foundation).
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% in 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
- Christian: 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- Sikh: 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- Buddhist: 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- Hindu: 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- Jewish: 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- Muslim: 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- Other: 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- None: 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
- Not stated: 6.66% of Cheshire East and 6.5% of Cheshire West & Chester
**Carers:** In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

**2.2 Evidence of complaints on grounds of discrimination:** (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the **policy, procedure, proposal, strategy or service** or its effects on different groups?)

| Nil |

**2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?**

| N/A |

**3. Assessment of Impact**

Now that you have looked at the purpose, etc. of the **policy, procedure, proposal, strategy or service** (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the **policy, procedure, proposal, strategy or service** on each of the strands listed below.

**RACE:**
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, racial groups differently? **Yes □ No X**

**Explain your response:**

This policy is intended for and is suitable for usage by patients of all races. Information in different languages can be accessed via the interpretation policy.

**GENDER (INCLUDING TRANSGENDER):**
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, different gender groups differently? **Yes □ No X**

**Explain your response:**

This policy is intended for and is suitable for usage by patients of all genders.

**DISABILITY**
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, disabled people differently? **Yes □ No X**

**Explain your response:**

This policy is intended for and is suitable for usage by all patients regardless of disability. Reasonable adjustments will always be made in order to ensure that all patients are treated in a fair and unbiased manner and consideration will always be given to caring for children in an appropriate environment taking into account all conditions or issues. Patient passports will be read and adhered to. Extra resources may be accessed such as interpreter services, written information in braille or other formats such as easy read to facilitate this.
AGE:
From the evidence available does the policy, procedure, proposal, strategy or service, affect, or have the potential to affect, age groups differently?  Yes ☐  No  X
Explain your response:
This policy is intended for and is suitable for usage by patients of all ages up to 18 years old or older if the transition process to adult services continues beyond this age.

LESBIAN, GAY, BISEXUAL:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently?  Yes ☐  No  X
Explain your response:
This policy is intended for and is suitable for usage by all patients regardless of sexuality.

RELIGION/BELIEF:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently?        Yes ☐  No  X
Explain your response:
This policy is intended for and is suitable for usage by patients of all religions.

CARERS:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently?        Yes ☐  No  X
Explain your response:
This policy is intended for and is suitable for usage by all patients including patients who are carers for are cared for.

OTHER: EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently?        Yes ☐  No  X
Explain your response:
This policy is intended for and is suitable for usage by all patients.

4. Safeguarding Assessment - CHILDREN

<table>
<thead>
<tr>
<th>a. Is there a direct or indirect impact upon children?</th>
<th>Yes X</th>
<th>No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
different groups of children and young people:

This policy is intended for use with all paediatric patients who require enteral feeding.

c. If no please describe why there is considered to be no impact / significant impact on children

5. Relevant consultation

Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?

Dietetics, Children’s Ward Sisters, Paediatric Consultants

6. Date completed: 17/08/2016 Review Date:

7. Any actions identified:

Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
</thead>
</table>

8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead

Approved by Trust Equality and Diversity Lead: ____________________________

Date: 18.8.16