POLICY & PROCEDURE NUMBER: ***4.19***
DEPARTMENT: *Dietary* **SUBJECT:** ***Enteral Feeding***

APPROVAL DATE: February 2011 **REVISION DATE:** January 2018
REVIEW DATE: Oct 2019; Dec. 2020

POLICY:

A resident requiring enteral (tube) feeding as a sole source or adjunctive nutrition support have access to a comprehensive enteral feeding program and receive appropriate support from an interdisciplinary team comprised of a physician, nurses and dietitian at a minimum.

The Registered Dietitian shall oversee the nutrition component of the enteral feeding program.

OBJECTIVES:

To provide optimum nutrition and hydration care for any resident requiring enteral feeding.

To provide appropriate social and emotional support within the limitations of enteral feeding.

PROCEDURE:

1. The Registered Dietitian (RD) will be notified as soon as possible of the planned admission of a resident requiring enteral feeding, or of the planned insertion of a feeding tube for a current resident.

2. Initiation of enteral feeding for a resident already in the home is based on assessment of the resident's clinical condition, the judgement of the interdisciplinary team, the Advance Directives and the resident's and family's wishes.

3. The following questions guide the team in deciding whether an enteral feeding should be considered: does the resident suffer from a condition that is likely to benefit from tube feeding; does the resident suffer from an incurable disease but one in which quality of life and well being can be maintained or improved with tube feeding; doe the benefit outweigh the risk; doe the tube feeding align with the expressed or presumed will of the resident or, in case of incompetence, of his/her Substitute Decision Maker.

4. The Home's Enteral Feeding Protocol is followed for all residents receiving enteral feeding. *Sample "Enteral Feeding Protocol" follows.*

5. When it has been determined that an enteral feeding will be initiated, the RD assesses the resident's current nutrition and medical status and calculates the estimated requirements for energy, protein, fluids, fibre, vitamins and minerals and recommends and enteral feeding formula based on these requirements.

6. The RD writes the feeding orders and routines, specifying formula product name (open or closed system), total volume to meet nutrient and fluid needs, method of delivery (pump preferably), rate of delivery, times of feeding (intermittent or continuous), and volumes and times of required water flushes. The orders are documented on physician's order form, in the interdisciplinary progress notes and in the Nutrition Care Plan.

7. The enteral feeding orders are documented by the RD on the physician's order form (to be co-signed by the physician, if required per Home policy), in the interdisciplinary progress notes and in the Nutrition Care Plan. The type of formula, total daily volume, method of delivery, rate of delivery, feeding times/schedule and volumes/times of the flushing schedule should be specified by the RD.

8. The RD is responsible for writing any changes to the enteral feeding orders; if the RD is not available, the physician *may* change the enteral feeding order; in this case, Nursing staff ensure that a written referral is made to the RD to assess the change.

9. All residents on enteral feeding are considered to be at high nutrition risk and are closely followed by the RD on a regular basis.

10. For residents being admitted to the Home who are already on enteral feedings, every effort is made to provide the same feeding formula and schedule as they were previously on. If the formula is not available for purchase because of supplier limitations, the RD is consulted and a nutritionally comparable product is provided.

11. The ordering of formula and enteral feeding equipment/supplies may be a Nursing or Dietary responsibility, depending on Home policy. A minimum 3 day supply of each enteral feeding product required for residents is kept on hand.

12. Nursing staff record each resident's intake of formula on a daily basis, and record each resident's weight on a weekly basis when the feeding is first initiated and until the resident is stable; the RD monitors these weights. Once stable, residents on enteral feeds

may be weighed monthly per the weighing / bath schedule.

13. Lab tests are ordered by the physician, with input from the RD as required, and monitored on a regular basis. *See "Enteral Feeding Protocol*

14. The RPN/RN and/or other interdisciplinary team members monitor each resident on every shift and evaluate the resident's progress and condition, check for symptoms of intolerance to the formula or administration method and for signs/symptoms of dehydration. Any concerns are reported to the RD and MD. The RD, or MD if the RD is not available, assesses the resident and changes the formula and/or feeding regime accordingly

15. Refeeding syndrome is a set of metabolic disturbances that occur as a result of re-introduction of nutrition to residents who are severely malnourished. Any resident identified as being at risk for refeeding syndrome should have enteral feedings initiated slowly and cautiously in order to avoid hypophosphatemia, hypokalemia and hypomagnesemia and their resulting neurologic, pulmonary, cardiac, neuromuscular and hematologic complications.

16. Each resident who is receiving enteral feeding is evaluated by the interdisciplinary / enteral feeding team to determine the appropriateness and safety for the resident to transition/return to oral feeds. If the team is questioning if this might be possible, a Speech Language Pathology assessment / modified barium swallow (MBS) is requested. If the SLP confirms that oral feeding is considered safe, an interdisciplinary plan of care is developed to facilitate the transition.

17. Ongoing evaluation is provided by the RD during the time of transitional feeding to ensure that the resident's nutrition and hydration needs are being met.

18. When residents on enteral feeding are <u>also</u> able to tolerate some oral foods *for pleasure* (in most cases, oral foods generally provide limited nutrition input) guidelines are provided by the RD for Dietary and Nursing staff as to what types of foods are safe and well tolerated, and positioning techniques for safe feeding.

19. All oral intake is documented in Point of Care documentation and the RD considers any nutrients obtained from the oral intake (if significant) and adjusts the enteral feeding accordingly.

20. For residents receiving oral *and* enteral feeds, the RD assesses oral intake on an ongoing basis and, if oral intake reaches a minimum of 75% of estimated needs, may consider discontinuing the enteral feeding, with input regarding this decision from the resident, family and interdisciplinary team members.

21. Ongoing education regarding enteral feeding is provided to Nursing, Dietary staff and other team members by the RD, or other health care professionals with expertise in enteral feeding, and by the manufacturers of enteral feeding products.

References

Nestle Nutrition Resource Manual for Long Term Care 2010

ASPEN guidelines on enteral nutrition: geriatrics, Clinical Nutrition 2006, 25:330 – 360

Nutrition in chronic management of the elderly. Nutrition in Clinical Practice 2003 18 3-11

Nursing policy – Enteral Feeding

ENTERAL FEEDING PROTOCOL
1. **Nutritional Assessment**: Consult Registered Dietitian (RD) for nutrition assessment to determine estimated nutrition requirements for energy, protein, fluids, fibre, vitamins and minerals; continue with same enteral feed regime as prior to admission/readmission *until RD* assesses. • RD determines type of formula, total volume, rate of feed, water flush and administration method. • RD writes the enteral feed order (formula, total volume to meet needs, rate, and times and volume of water flushes) in the physician's orders, to be co-signed by the physician, per Home policy. • RD develops the Nutrition Care Plan and follows the resident as at HIGH nutrition risk.
2. **Supplies**: Formula is ordered by Dietary, supplies (spike sets, syringes) by Nursing, or per Home policy. (Min. 3 day supply)
3. **The Head of Bed is Elevated** (HOBE) to a minimum 30º - 45º during enteral feeding as well as for 30 to 60 minutes' post feeding (if intermittent) to minimize risk of reflux and aspiration.
4. **Nursing Staff Label the Feeding Container** unless otherwise labelled.
5. **Before Starting the Tube Feed**, the RPN/RN checks the placement of tube as well as the pump settings to ensure accuracy of administration. The RPN/RN primes the tube (manual or automatic) to minimize risk of air entry.
6. **Mouth Care** is completed twice per shift.
7. **Tube site care** is performed as ordered by the physician. Skin integrity around the site is monitored regularly
8. **Tube integrity** is monitored by all registered staff to determine if/when the tube needs to be changed. If a clog is suspected refer to nursing policy – "Enteral feeding"
9. **RPN/RN Assess Tolerance** to the enteral feeding formula and administration method by monitoring and documenting, during every shift, for nausea, vomiting, cramps, diarrhea, distention, constipation. If any symptom is observed, it is to be documented in the multidisciplinary notes and the physician and RD are notified.
10. RPN/RN also **Monitor for Signs/Symptoms of Dehydration**. If present, the physician and RD are notified.
11. **The RPN/RN also Assess Breath Sounds**. If rhales, rhonci or congestion is present, the tube feed is stopped and the physician notified immediately.
12. **Weight is taken and recorded** on a weekly basis and monitored by the RD. Once stable, weights can be taken monthly.

13. **Labs are ordered** as per physician. Recommended monitoring guidelines as follows:

PARAMETER	INITIAL FREQUENCY	LONG TERM FREQUENCY
BUN, electrolytes, glucose, serum creatinine	On admission	Every 3 months/PRN
Serum calcium, phosphorus, magnesium, liver enzymes	On admission	Every 3 months/PRN
24-hour BUN and creatinine excretion, total iron-binding capacity or serum transferrin	On admission	Every 3 months/PRN
Serum triglycerides and cholesterol	On admission	Every 3 months/PRN
Serum albumin	On admission	Every 3 months/PRN
Frequency of monitoring may be decreased if stable on tube feeding as ordered by physician.		

14. **Speech Language Pathology**, if available, is consulted to assess if the resident may return to oral feeding.

15. **If the resident is having oral intake along with tube feeding**;

a) oral intake is documented

b) the RD assesses oral intake vs. estimated needs, adjusts enteral feeding accordingly & considers discontinuing enteral feeds when the resident is consuming ~ 75% of needs orally.