SARASOTA MEMORIAL HOSPITAL

NURSING PROCEDURE

TITLE: ADMINISTRATION OF A FEEDING (CONTINUOUS OR INTERMITTENT) OR MEDICATION VIA A GASTROSTOMY TUBE-ADULT (tuf04)

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PAGES: 1 of 8

ISSUED FOR: Nursing

RESPONSIBILITY: RN, LPN

PURPOSE: Surgical method of providing nutrition or medication when the oral or mouth-to-stomach route is contraindicated.

OBJECTIVE: To administer liquid feeding or medication at appropriate times.

KNOWLEDGE BASE:
1. Follow established policy and procedures for the administration of medications, including checking the medication label against the Medication Administration Record (eMAR) and properly identifying the patient.

2. For a gastrostomy feeding, check the physician’s order for the prescribed feeding. Use the “Tube Feeding order set” in SCM.

PROCEDURE:
Explain the procedure to the patient and provide privacy. If appropriate, instruct the patient/support person in self-care.

CHECKING TUBE FOR PATENCY:
1. Place the patient in a comfortable semi-Fowler’s (30° elevation minimum) position.

2. Perform hand hygiene; apply gloves.

3. Aspirate stomach contents to determine amount of residual every 4 hours or as ordered by physician. Hold feeding for two hours if residual volume greater than 400 ml. Alert MD if residual remains greater than 400 ml after two hours. Return up to 200 ml of aspirated contents to stomach to prevent electrolyte imbalance.

4. Check for leakage of fluid around the tube or excoriation of skin around the tube. Pinch off tubing after patency is assured.
EQUIPMENT (for med administration)

ADMINISTERING MEDICATIONS:

Assemble the following:

a. Catheter-tipped syringe  
b. Medication to be administered. If at all possible obtain liquid forms from Pharmacy  
c. Mortar and pestle (if needed)  
d. 50 ml room temperature water  
e. Towel  
f. Gloves

PROCEDURE (for med administration)

ADMINISTERING MEDICATIONS:

1. Remove the plug at the tip of the gastrostomy tube and attach the syringe. Release the clamp and instill about 10 ml water to check for patency. The water should flow in easily if the tube is patient.
2. Proceed with administering medicine in liquid form or pills that have been crushed and mixed in water. Release pinched tubing and allows medicine to flow into stomach by gravity method.
   
   **NOTE**: Any enteric-coated or sustained-released drugs should not be administered as their effectiveness will be altered when crushed. Clarify with physician or pharmacist if ordered.

   **NOTE**: Liquid Tylenol is not recommended as its viscosity tends to obstruct the tube.

   **NOTE**: The absorption of the following enteral medications is inhibited with tube feedings: Ciprofloxacin and Phenytoin (Dilantin). Hold tube feeding 1 hour before and 2 hours after administration of enteral Ciprofloxacin and 1 hour before and 1 hour after the administration of enteral Phenytoin (Dilantin).

   **NOTE**: Consult with the physician and/or Dietitian if tube feeding must be held due to the administration of these meds in case he wants to titrate/adjust the tube feeding because of this.

3. Pour a small amount of water, approximately 30 ml to clear the tube. Release pinched tubing. Clamp off gastrostomy tube after instillation of water.

4. Keep the head of the bed elevated for 30 minutes after medication administration to assist with digestion.

ADMINISTERING CONTINUOUS FEEDING:
(RN or LPN) (use the “Tube feeding order set” in SCM)

NOTE: A Lopez enteral valve can be used for feeding. Attach Lopez valve directly to the tube. Insert the feeding set securely into the universal adapter. Turn the “OFF” indicator towards the medication port. The arrows will show the fluid flow from the feeding device to the patient.

The most common change protocol for the lopez valve in an acute care setting is weekly. (ICU Medical, Inc.)

CLOSED TUBE FEEDING SYSTEM:

1. Kangaroo Epump Safety Screw Spike with flush bag
2. Ordered 1-liter Enteral nutrition container (feeding).
3. Infusion pump.
4. 60 ml syringe
5. Stethoscope
6. Water to fill flush bag, if used.

IF CLOSED TUBE FEEDING SYSTEM NOT USED:

Assemble the following:
1. Kangaroo Epump Spike with flush bag
2. Prescribed tube feeding formula.
3. Infusion pump
4. 60 ml syringe
5. Stethoscope
6. Water to fill flush bag, if used.

NOTE: Check the date on all formula containers. Discard all powdered formula within 24 hours of mixing it.

CLOSED TUBE FEEDING SYSTEM – 24 HOUR SYSTEM (this is the preferred method for continuous feedings)

1. Provide privacy and perform hand hygiene.

2. Inform the patient about the procedure for receiving nourishment through a tube.

3. Elevate the patient’s bed to a high or semi-Fowler’s (at least 30 degrees) position to prevent aspiration by gastroesophageal reflux and to facilitate digestion.

   CAUTION NOTE: May need to clarify with the physician if feeding can be interrupted for procedures (i.e., CPT, diagnostic tests, therapy) or if the head of the bed cannot remain elevated during a continuous tube feeding.

4. Remove the cap or plug from the feeding tube. To check its patency and position, use the syringe to inject 10 ml of air through the tube while auscultating the patient’s stomach.
with a stethoscope. Listen for a whooshing sound. Aspiration of stomach contents also confirms that the tube is patent and properly positioned.

5. Fill or spike feeding container and water bag prior to setting up pump. Turn pump on by pressing power button. (FEEDING SET BAG MUST BE 18 INCHES ABOVE THE TOP OF THE FEEDING PUMP) Select “keep settings” or “clear settings” Load the set per diagram on panel (DO NOT OVERSTRETCH).


7. Setting the feeding rate: Select “adjust feed” then “feed rate” using the buttons adjust from 1 ml to 400 ml as ordered by physician. Select “enter” when ordered rate is set.

8. Setting the flush rate: Select “adjust flush” then “flush volume” set the volume of water per flush cycle from 10 to 500 ml’s. Select “enter” when physician ordered flush rate is set.

Select “flush interval” to define the time interval between the start of each flushing cycle from 1 to 24 hours as ordered by physician. Select “enter” then “done” then Select “done”

9. The use of this closed tube feeding system replaces the need for routine flushing procedures as the pump will automatically flush what has been entered. Check with MD to see if they want the automatic flush administered.

10. **To change rate or clear volume:** Select “hold” then select “clear volume” then select “adjust settings” to adjust all settings then select “run”

11. If pump feeding is manually stopped or turned off, automatic flushing does not occur. If pump remains in OFF mode (not on HOLD), it is recommended to flush with 20-30 ml of warm water (use a 30 ml syringe) to rinse remaining product from the feeding set.

12. Check bowel sounds at least every shift or more often as indicated. Assess for complaints of fullness and/or abdominal distention.

*Aspirate stomach contents to determine amount of residual every 4 hours or as ordered by physician. Hold feeding for two hours if residual volume greater than 400 ml. Alert MD if residual remains greater than 400 ml after two hours.*
PROCEDURE (for continuous feedings - closed system not used)

13. Change feeding tubing and supplement every 24 hours.
   Apply a label with date, time/initials, formula and rate.

14. If the patient becomes distended, nauseated or vomits, stop the feeding immediately. Notify the physician.

IF CLOSED TUBE FEEDING SYSTEM NOT USED:

1. Provide privacy and perform hand hygiene.

2. Inform the patient about the procedure for receiving nourishment through a tube.

3. Add the tube feeding to the feeding bag. Fill flush bag with water (if ordered). Set the rate ordered by physician as instructed above.

4. Elevate the patient’s bed to a high or semi-Fowler’s (at least 30 degrees) position to prevent aspiration by gastroesophageal reflux and to facilitate digestion.
   CAUTION NOTE: May need to clarify with the physician if feeding can be interrupted for procedures (i.e., CPT, diagnostic tests, therapy), or if the head of the bed cannot remain elevated during a continuous tube feeding.

5. Remove the cap or plug from the feeding tube. To check its patency and position, use the syringe to inject 10 ml of air through the tube while auscultating the patient’s stomach with a stethoscope. Listen for a whooshing sound. Aspiration of stomach contents also confirms that the tube is patent and properly positioned.

6. Connect the feeding bag tubing to the feeding tube.

7. Thread the tubing through the continuous pump device and set at the rate ordered by the physician as described above. Add the feeding formula to the bag. Use only the amount of formula to be infused in four hours. Completely infuse each 4-hour amount. Flush the tubing with warm water (50ml) every 4 hours unless physician orders automatic flush system (25 ml/hr) to be utilized.

8. Check bowel sounds at least every shift or more often as indicated. Assess for complaints of fullness and/or abdominal distention.

*Aspirate stomach contents to determine amount of residual every 4 hours or as ordered by physician. Hold feeding for two hours if residual volume greater than 400 ml. Alert MD
if residual remains greater than 400 ml after two hours. Return up to 200 ml of aspirated contents to stomach to prevent electrolyte imbalance (ASPEN, 2016).

9. Change feeding tubing every 24 hours. Apply a label with date, time/initials, formula and rate.

10. If the patient becomes distended, nauseated or vomits, stop the feeding immediately. Notify the physician.

ADMINISTERING INTERMITTENT BOLUS FEEDINGS:

EQUIPMENT (for intermittent feedings)

Assemble the following:

a. Feeding formula
b. Catheter tip syringe, 60 ml
c. 60 ml water
d. Towel

PROCEDURE (for intermittent feedings)

1. Perform hand hygiene. Place a towel over the patient’s gown. Elevate the patient’s head of the bed to a high or semi-Fowlers position to facilitate digestion.
2. Obtain the formula ordered and check the date for any expired formula.
3. Remove the cap or plug from the feeding tube. Use the catheter-tipped syringe to determine the amount of residual. Hold feedings if residual volume is greater than the pre-determined amount specified in the MD order. Return up to 200 ml of the aspirated contents to the stomach to prevent electrolyte imbalance.
4. Remove the plunger and attach the 60 ml catheter-tipped syringe to the pinched off feeding tube to prevent excess air from entering the patient’s stomach and causing distention.
5. Fill the syringe with formula and release the feeding tube to allow the formula to flow through it. The height at which the syringe is held will determine the flow rate. Hold no higher than 18 inches above the patient. When the syringe is three-quarters empty, pour more formula into it (don’t allow the syringe to empty completely).
6. Administer the feeding slowly, generally 200-350 ml over 15-20 minutes depending upon patient tolerance and the MD orders.
7. After administering the ordered amount of formula, flush the tubing by adding 60 ml of water to the syringe. This helps to maintain patency of the tube.
8. Disconnect the syringe from the feeding tube, cover the end of the feeding tube with a plug or cap.
9. Leave the patient in a high or semi-Fowlers position for at least 60 minutes.
10. Rinse the syringe with water. Change the syringe every 24 hours.

**DOCUMENTATION:**

1. **Medication Record (eMAR):** Document the medication per established procedure.

2. **I&O Flowsheet:** Enter the amount of fluid taken on the Intake and Output Sheet.

3. **Nursing Reassessment:** Document the patient’s response to treatment and any other pertinent data.

**REFERENCE:**


SMH Policy (01.PHM.12). Food-Drug Interactions. SMH; Author.


