



# Family Nursing & Home Care

## **Policy and Procedures for the care of an infant, child or young person who requires enteral feeding**

**6<sup>th</sup> April 2022**

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This policy and procedures were originally adapted for local use by Family Nursing & Homecare and the Health and Community Services Dietetic Department from the 2015 Guidelines and Audit Implementation Network (GAIN) 'Guidelines for caring for an infant, child or young person who requires enteral feeding'. Permission to adapt these guidelines for use in Jersey was granted at that time by GAIN.

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## 1. INTRODUCTION

### 1.1 Rationale

There are a growing number of children and young people in settings such as hospitals, homes, schools and respite facilities who require various enteral feeding regimes to achieve effective nutrition. Multi professional teams provide support to ensure the safe and effective management of all aspects involved with enteral feeding. It is therefore essential that all staff, families and carers have the necessary knowledge and skills to provide safe and effective person centred care.

This policy aims to:

- Ensure that all practices associated with the commencement, care, management and replacement of enteral feeding devices in children are based on best current evidence
- Standardise practice both for the management of enteral feeding and replacement of enteral feeding devices to ensure a consistent approach for staff and families
- Provide a standardised approach to training for all staff and parents/carers (eg at school/nursery) whose children require enteral feeding
- Improve communication processes between hospital and community for children requiring enteral feeding

### 1.2 Scope

These guidelines are for use by any member of staff involved with infants, children or young people who are either totally or partially fed using an enteral feeding device. It outlines the roles and responsibilities of different professional groups to ensure co-ordinated multi-disciplinary best practice.

Throughout the guideline, the term 'children' or 'child' will cover infants as well as young people.

N.B This guideline excludes neonates/ pre-term babies because their physiology is different to that of an older baby. As a result, staff caring for such babies within neonatal units should adhere to national, regional and local guidance.

### 1.3 Role and Responsibilities

**Chief Executive Officer** - has overall responsibility for ensuring there are effective arrangements in place so that staff are appropriately trained and competent to effectively fulfil their role within the organisation and to maintain the safety of patients.

**Director of Governance and Care** – will ensure systems are in place to update this policy in line with evidence based practice. Monitor, report and investigate incidences reported on Assures related to restrictive physical interventions and the clinical holding of children and young people.

**Policy Clinical Lead (Author)** – The Policy Lead will oversee the implementation and promotion of the policy across the organisation. They will be responsible for monitoring and reviewing the policy as necessary.

**Education and Development** – is responsible for ensuring that education governance arrangements are in place to ensure the effectiveness of the delivery of physical intervention across the Organisation and those models of teaching, learning and assessment are fit for purpose.

**Operational Leads** - are responsible for ensuring that high standards are maintained within their areas of responsibility and the standards set out in this policy are adhered to.

**Team Leaders** – It is the responsibility of each team leader to ensure staff attend all relevant statutory and mandatory training; and to monitor attendance on a routine basis. They must ensure all appropriate equipment is available and in good working order and ensure staff are appropriately trained, up dated and competent in the process within this policy.

**Employee** – it is the responsibility of each staff member to ensure they attend all relevant mandatory training and other training if relevant for their role to keep up to date and comply with this policy.

## 2. POLICY

### 2.1 Enteral Nutrition

Enteral nutrition is the provision of safe and effective nutritional support through the use of an enteral feeding device. It is generally required when a child is unable to meet their nutritional and/or hydration needs orally. The enteral device may also be used for aspiration purposes, venting and/or administration of medications. Enteral devices are situated in the gastrointestinal tract - stomach/jejunum/duodenum.

Enteral feeding aims to:

- Provide effective nutrition support.
- Empower the child and/or family to participate in nutritional care decisions.

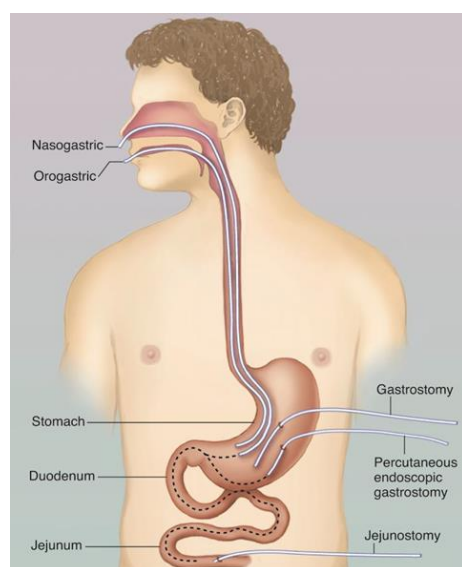
Enable provision of feeding in all hospital and community settings taking into account the unique needs of each child

## 2.2 Enteral Feeding Devices

The table below indicates the different routes and types of enteral devices currently being used with children. Also included are indications for use and potential risks.

Type of Enteral Feeding Device	Placement and Use	Indications	Potential Risks
<b>Orogastric Tube</b>	A feeding tube passed through the mouth directly into the stomach  Bolus/continuous feeds	More commonly used in neonates  Inability to maintain adequate oral intake of nutrition / medicines/fluids  Fractured base of skull	Difficulty in obtaining aspirate to check position  Aspirate may have a pH reading above 5.5 due to medications  Accidental dislodgement  Tube migration or misplacement into oesophagus/lung
<b>Nasogastric Tube (Two types)</b>  Short Term use  Long term use	A narrow tube that is passed into the nose and down the oesophagus into the stomach, which allows liquid feed/medication to be delivered directly into stomach.  Bolus/continuous feeds	Inability to maintain adequate oral intake of nutrition / medicines/fluids	Trauma to mucosa blockage
<b>Gastrostomy Devices</b>  Percutaneous Endoscopic Gastrostomy (PEG) tube	Feeding devices which allow liquid feed, fluids and/or medicines to be delivered directly into the stomach  Suitable for Bolus/continuous feeds Venting and/or aspiration purposes	Long-term Inability to maintain oral intake	Accidental dislodgement  Tube migration  Granulation at stoma site  Infection
Button/Low profile device  Non-balloon gastrostomy tube  Balloon gastrostomy tube (also called a replacement gastrostomy or G tube)	An initial gastrostomy tube can be inserted endoscopically, radiologically, surgically or percutaneously in a surgical theatre environment		Buried Bumper (internal plate has become buried in stomach wall)  Blockage

Type of Enteral Feeding Device	Placement and Use	Indications	Potential Risks
<b>Nasoduodenal tube</b>  <b>Nasojejunal tube</b>	A polyurethane tube which is inserted via nose through the stomach and into either the duodenum or jejunum  Position confirmed radiologically  <b>Continuous</b> feeds only	Inability to maintain adequate oral intake of nutrition / medicines/fluids  Delayed gastric emptying  Gastro-oesophageal reflux resulting in risk of aspiration	Trauma to entry site Infection Tube misplacement/migration  Accidental dislodgement of tube  Small bowel intussusception  Tube blockage  Electrolyte imbalance with large gastric losses
<b>Transgastricjejunal tube (gastrojejunostomy)</b>	Long term use  Balloon type devices placed endoscopically or radiologically via an established gastric stoma  <b>Continuous</b> feeds only	Intractable vomiting  Delayed gastric emptying Motility disorder Anatomical anomaly	
<b>Jejunostomy</b> Balloon Button Device  Tube device  G tube with external fixator	Long term use  Enteral feeding device inserted surgically into the jejunum  <b>Continuous</b> feeds only		



Nasoduodenal, nasojejunal, and percutaneous endoscopic jejunostomy tubes extend (dotted line) to the small intestine instead of ending in the stomach

Illustration © Taina Litwak 2008



Before accessing an enteral feeding device it is essential the following is known:

- Reason(s) for the enteral device e.g. feeding, medicines, aspiration, venting
- When, where and how was the enteral device inserted
- How the device is secured e.g. anchoring sutures
- The type/size of enteral device used and how it is retained
- Where the tip of the enteral device is situated – stomach/small intestine

This information should be recorded in the child's records and included as part of the Hospital Discharge Information document when a child goes home from hospital (Appendix 1).

## **2.3 Infection Prevention and Control**

There are associated infection risks with enteral feeding due to potential contamination during feeding preparation and administration.

Aseptic Non-Touch Technique (ANTT) principles should be applied when preparing feeds and throughout the duration of enteral feeding.

Effective hand decontamination by the person preparing and administering the enteral feed should be adhered to.

Personal protective equipment such as gloves and aprons should be used by healthcare workers.

In order to minimise infection, all aspects of care relating to enteral feeding must be taught to parents/carers before the child is discharged from hospital.

Instructions regarding cleaning of reusable syringes, extension sets and feeding pump are to be discussed and provided to family.

All disposable items should be bagged and placed in the household bin. Enteral syringes cannot be put into the household recycling bin.

## **2.4 Disposables required for enteral feeding**

A risk assessment should be undertaken for each child taking into account susceptibility to infection and the care setting in order to establish if disposable products required are 'Single Use' or 'Single Patient Use'.

- 'Single use only' - cannot be reused.
- 'Single patient use' i.e. can be reused only on the same child following cleaning. These should be replaced as per the manufacturer's recommendations

Syringes used for enteral feeding are purple and marked for enteral use

A 20/50ml\* purple enteral syringe is recommended, where possible, because the larger the syringe the less pressure that is delivered to the enteral device and this prevents potential damage to internal tubing of enteral device

In the community, 'Single patient use' home enteral syringes are most generally used, unless the child's risk assessment identifies the need for 'single use only'.

Disposables required for feeding will vary depending on the Dietician's regimen for the individual child for e.g. bolus/intermittent/continuous feeding.

- The enteral feeding system should be compatible with the child's enteral feeding device.
- Extension sets that are reusable may be required for administration of feed e.g. button gastrostomy.

Locally, both Dieticians and Community Children's Nurses can 'prescribe' equipment for enteral feeding from the approved list of products on the 'Subsidised Products Scheme'. The required equipment is then purchased by parents at a reduced rate from an authorised pharmacy on the production of a 'Subsidised Product Scheme' voucher.

\*Reference to 50ml syringe includes 50/60ml syringe

## **2.5 Enteral Feeds**

There are two types of feed:

- Ready to use feeds which have been specially prepared and pre-packed. These are ideally administered with a closed system. In some cases these may have to be decanted. This is agreed with the Dietician and family.
- Reconstituted feeds are feeds which come in a powdered form and need to be prepared before use.

In Jersey, only Dieticians can 'prescribe' enteral feeds which can then be purchased by parents at a subsidised rate. As with the consumables, the feeds can be obtained from an authorised pharmacy when a 'Subsidised Product Scheme' voucher is presented.

Initial and on-going/annual training will be provided to family and carers to maintain proficiency and prevent complications. This will include basic food hygiene principles, for example, hand washing and cleaning of the preparation area and utensils.

### **2.5.1 Methods of administration**

There are two methods of enteral feeding:

- Bolus feeding which can be given by the gravity method or feeding pump (Intermittent)
- Continuous feeding using a feeding pump (usually over 20-24hrs daily)

#### Intermittent and/or Bolus Feeding:

Intermittent and or bolus/gravity feeding is the administration of small frequent feeds at regular intervals. It is more physiological than continuous feeds as it stimulates a normal and enzymatic feeding response. This also enables a more 'normal' life for child's family as it allows time lapse between feedings.

#### Continuous feeding:

Continuous feeds are the administration of a feed at a slower rate over a prolonged period of time. This is indicated when a longer, slower feeding time is more appropriate for the child.

Jejunal/ duodenal feeds are ALWAYS administered over a longer slower period of time. The decision to feed continuously overnight must be clearly identified and documented by Dietician/Consultant and a risk assessment and management plan should be discussed with parents and documented.

### **2.5.2 Use of liquidised/blended food**

The administration of liquidised food via an enteral feeding tube is not currently recommended by the British Dietetics Association due to the risk to nutritional inadequacy. Use of liquidised food also increases the likelihood of feeding tube blockage and the risk of gastric infection. It could pose particular risks to infants less than six months, jejunal fed patients or those immuno-compromised.

The emotional needs and preferences of parents/carers considering the use of liquidised/blended food should be taken into account alongside the clinical needs of the child. However, they need to be made aware of the potential risks to health and the viability of the child's feeding tube. Practitioners should ensure that a full risk assessment is carried out and that they work within their employers' clinical governance guidance and risk management frameworks.

Staff should seek Dietetic advice if blended/liquidised food is being considered by the family/child. The clinical team must discuss and record the reasons for the parent wanting to commence liquidised food via the enteral feeding tube and ensure that all alternative commercial food formulations and feeding strategies have been considered.

## **2.6 Administration of medications via an enteral feeding device**

Parents/carers/health professionals should be aware of the risks associated with administration of medicines via enteral feeding devices.

Medicines prescribed for administration via the enteral route should be in a suitable formulation e.g. liquids or soluble tablets. If a medicine is not available in a liquid or soluble form, it may be necessary to crush a tablet or open a capsule. Always refer to a Pharmacist for guidance on suitable formulations and suitability of crushing tablets or opening capsules.

A very limited number of medicines are licensed for administration via enteral feeding devices and most administration of medicines via this route falls outside the product license for that medicine, as does crushing tablets and opening capsules not specifically designed for this purpose. However, this may be the only option for administration of a particular drug.

If medicines are to be administered via an enteral feeding device and this is outside of the medicines product license, it is important everyone involved in the prescription, supply and administration of the medicine is aware, in the event of any adverse effects resulting from administration via this route.

A structured medicines review should be carried out on an individual basis for each patient prior to administration of medicines via an enteral feeding device. Any unnecessary medicines should be discontinued and where possible, drug therapy should be kept to a minimum and alternative licensed routes of administration used if appropriate.

For general guidance on administration of medicines via enteral feeding devices see FNHC Medicines Policy. Risk assessment guidance is detailed in Appendix 3.

## **2.7 Checking the position of enteral feeding devices**

The position of all newly inserted devices should be checked and also before and after changing a gastrostomy device to ensure the tip of the device is in the correct position.

Until initial placement has been confirmed, orogastric and nasogastric tubes must not be flushed, nor guidewires pre-lubricated, nor must anything be introduced through the tube. (NHS Improvement 2016)

The position of nasogastric/nasojejunal/nasoduodenal tube must be rechecked following episodes of vomiting, retching or coughing spasms or when there is a suggestion of tube displacement/dislodgement. Indications of this include unusual leakage of stomach contents around site, unusual redness or swelling around site, excessive vomiting and/or abdominal distension or pain.

The position should also be checked if there are indications of any new or unexplained respiratory symptoms.

## **2.8 Flushing enteral devices**

Flushes are required (after confirming the correct position of device):

- Before and after each medication administration.
- Before and after feeding.
- Daily if the enteral device not currently in use
- During continuous feeds the tube should be flushed every 4-6 hours

## **2.9 Removal of the enteral feeding device**

The decision to remove the enteral feeding device will normally be made when the child is eating and drinking adequately and following a clinical review. An individualised care plan will be agreed following a multi-disciplinary team meeting which may include the Surgeon/Gastroenterologist, Paediatrician, GP, dietician, nurse, carer and the child/family.

## **2.10 Staff Training and Competence**

Any individuals involved in enteral feeding should receive initial training to obtain competencies and on-going training to maintain competencies. Training must reflect all safety-critical requirements summarised in the resource set developed by NHS Improvement (NHS Improvement 2016). Records should document competencies achieved based on local guidelines. New staff/student nurses will be supervised and supported by a member of the Children's Community Nursing Team (CCNT) until they feel confident with care of the gastrostomy/nasogastric tube, including administration of feeds (if this is appropriate to their role). Competency will be assessed and recorded using the appropriate documentation (see appendix 6 & 7).

Evidence of poor compliance or standards should be referred to the team leaders, operational lead and education department in order for development plans to be devised and additional training assessed.

### **3. PROCEDURES**

#### **3.1 Discharge from hospital to home setting**

The CCNT should be contacted as soon as the child has been identified as requiring enteral feeding support within the community.

The CCNT should contact the family following discharge and arrange a home visit.

Most enteral feeding devices are initially inserted in the UK. If the child has been discharged from a UK hospital directly to the community, the CCNT should check that they have all the necessary information eg type, size and length of enteral device, feeding regimen, training provided to parents/carers. Where information is missing, this must be requested from the discharging hospital.

Where the child is being discharged from Robin Ward at the hospital, the Hospital Discharge Information document (Appendix 1) should be completed before discharge and a copy sent to the CCNT.

Before accessing an enteral feeding device it is essential to know the following:

- Reason(s) for the enteral device e.g. feeding, medicines, aspiration, venting
- When, where and how was the enteral device inserted
- How the device is secured e.g. anchoring sutures
- The type/size of enteral device used and how it is retained
- Where the tip of the enteral device is situated – stomach/small intestine

Parents/carers should be enabled to be involved in the management of the child's enteral feeding device as soon as possible following insertion. Where possible, the child should be empowered by staff and family to contribute to the management of their enteral feeding.

If a child is discharged within 72 hours of gastrostomy insertion - an alert is to be included in the child's care records **and** discharge information (if discharged from Robin Ward) and parents/carers should be instructed to STOP feeding and seek urgent medical advice immediately if the child experiences the following:

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

### 3.1.1 Training of parents/carers

Before discharge, parents/carers should receive training and be deemed competent in all aspects of their child's enteral feeding device and feeding regimen.

The training delivered to parents/carers should be provided by a registered professional who is competent in all aspects of enteral tube feeding.

The training of parents/carers should include:

- Minimising the control and risk of infection e.g. hand washing, cleaning of equipment and food safety awareness.
- Type, make and size of the enteral device.
- Feeding pump (if required)
- General management of the enteral device including:
  - ✓ Checking position
  - ✓ Flushing
  - ✓ Administration of feeds/fluids/medicines
  - ✓ On-going care of stoma site
  - ✓ Troubleshooting guidance, including the accidental dislodgement of device

A record of competencies must be forwarded to the CCNT and entered onto EMIS and the child's hospital electronic record (EPR). The CCNT will be responsible for providing annual training updates within the community setting and at any stage when there has been a change in the child's enteral device and/or feeding regimen. The CCNT will also provide training to any additional carers\*\* who may become involved in the child's care post-discharge. Competency will be assessed and recorded using the appropriate documentation (see appendix 6).

\*\* excluding education staff passing a nasogastric tube

## 3.2 Management and observation of enteral feeding device

### 3.2.1 Enteral device inserted via oral/nasal passage

- These devices must be radio-opaque throughout their length and have externally visible length markings. (NHS Improvement 2016)
- Ensure device is securely taped in position and always replace tape if it appears to be loose
- Use a soft hypoallergenic dressing on face for securing device and check facial skin daily for any reactions to tape/pressure
- Avoid unnecessary pressure to nasal/oral passage when applying securing tape
- Use alternate nostrils on tube replacement where possible and document

- A nasogastric tube must only be replaced by a person who is competent and trained to do so (i.e. parent or registered nurse **only**) and position confirmed before use. Some nasogastric tubes can be washed and reused as per manufacturer's guidance
- Nasojejunal/duodenal tube must only be replaced **in hospital**

### 3.2.2 Gastrostomy/jejunal devices

#### Care of stoma site

- During the initial 24 hours the enteral device stoma site should be covered with a non-occlusive sterile dressing. This should be placed under fixation plate if used. Extension plate should be placed to avoid pressure at stoma site.
- Record the number visible at the fixation plate in the child's notes.
- On Day 1 dressings should be removed post-operatively and site left exposed unless exudate is present.
- Clean daily using Aseptic Non Touch Technique with sterile water until stoma site has healed which can take at least two weeks. Gently dry thoroughly.
- Use gauze that does not shed fibres when cleaning stoma site.
- Always ensure the stoma site is thoroughly dried. Do not apply any creams or talcum powder.
- The child may have a shower following discharge from hospital ensuring the enteral device is not submerged under water.
- The child may have a bath once the stoma site has healed.
- Once stoma site is healed the enteral device tubing, tube and surrounding skin should be cleaned and dried daily with non-perfumed hypoallergenic soap and fresh tap water.
- Discuss with Health Professional if child is able to go a swimming pool - stoma site must be healed
- Clean stoma site as previously advised following the swimming pool
- Always observe stoma site and surrounding skin for signs of inflammation, swelling, exudate and discomfort. If there are any concerns contact CCNT.

### Management of external fixation plate

- Do not move external fixation device until instructed to do so and training provided. Fixation plate is then adjusted on a weekly basis. Avoid taping tube to abdomen
- When the stoma tract is established the position of the external fixation plate can be marked with an indelible marker – as the child gains weight it may be necessary to renew the indelible marking

### Rotation of enteral device

- Initial rotation/advancement of the gastrostomy device is dictated by the surgeon and each child is individually assessed as to when this will commence. Thereafter the enteral device should be rotated 360 degrees on a daily basis. If there are any concerns contact CCNT.
- Jejunal devices should not be rotated

### Clamp on enteral device

- When tube is not in use, the adapter end should be closed and the clamp left open or repositioned daily.

### Balloon enteral devices

- Check and change the water once a week using sterile water
- Replace the enteral device as per manufacturer's advice and according to training provided
- Always check device is in correct place before and after placement by aspirating contents and checking pH value. Gastric confirmation should be pH value 5.5 and below; small bowel confirmation should be pH value 6-8
- Measure stoma size annually or sooner if the child has gained or lost excessive weight

## **3.3 Checking the position of enteral feeding devices**

- The position of a nasogastric/naso-jejunal/naso-duodenal tube must be checked, confirmed and documented following initial insertion, before administering each feed, before giving medications/flush and at least daily when not in use
- Do not use the 'whoosh test' or 'bubble test' to confirm orogastric or nasogastric tube placement.
- If there are any difficulties in obtaining aspirate refer to decision tree (NPSA 2011) (Appendix 2) Also refer to the FNHC Policy and Procedures for Insertion of a Nasogastric Tube and Initial Placement Checks



- For orogastric and nasogastric tubes - do not interpret absence of respiratory distress or the appearance of aspirate as an indicator of correct positioning. (NHS Improvement 2016)
- Correct gastric tube position is confirmed with a gastric aspirate pH value between 1 and 5.5. DO NOT USE THE DEVICE if pH value is above 5.5. Every pH test (including those where there is failure to obtain aspirate) and test result must be documented in the patient's records.
- Children taking antacids, H2 antagonists or proton pump inhibitors are likely to have a stomach pH greater than 5.5 in which case it may be difficult to confirm tube placement with the necessary accuracy. The need to continue this medicine should be reviewed by the prescriber against the need to feed via gastric tube. Additionally individual risk assessments on a case by case basis may be required
- Correct small bowel position (jejunum/duodenum) is confirmed with pH value 6-8. N.B. Nasojejunal/duodenal tubes must only be inserted/replaced in hospital as correct placement must be confirmed radiologically
- Ensure pH strips are CE marked, stored correctly and within expiry date. They must also be suitable for human gastric aspirate

### **3.4 Flushing enteral feeding devices**

- A 20ml/50ml enteral syringe should be used for flushing
- Use a pulsatile flushing action ('Push/pause technique') when flushing to promote a turbulence effect within the tube. This ensures adequate flushing of device and will help to prevent any blockages of enteral device and promote patency of the tube
- Use freshly drawn tap water for children who are receiving nasogastric or gastrostomy feeds in the community care setting, and are not immuno-compromised
- Use cooled freshly boiled water or sterile water from a freshly opened container for children who are immunocompromised, this includes children who require jejunal feeding
- The volume of flush will be advised by the Dietician and indicated on the child's care plan
- Record volumes of flushes administered in the child's care record.

### 3.5 Administration of Enteral Feeds

- Ready to use feeds are the preferred choice in preference to feeds that require decanting, reconstitution or dilution. The most appropriate feed will be prescribed for the child
- All feeds must be used within the marked expiry date.
- Store 'ready to use' feeds in a cool, dry place out of direct sunlight. Avoid storing feeds in gardens sheds/garages and next to radiators.
- 'Ready to use' feeds may be given as a continuous feed, within a closed administration system, up to a maximum of 24 hours once opened.
- Where a feed has been decanted into a feeding administration set, this should be administered within 4 hours and written in the individualised care plan.
- Avoid wastage where possible; once opened, the remaining 'ready to use' feed should be labelled with date and time it was opened, refrigerated and disposed of after 24 hours if not used.
- Reconstituted feeds should be made up with hot water of at least 70 degrees Celsius. To do this, boil the kettle with at least 1 litre of water and leave it to cool for no longer than 30 minutes (BDA 2019).
- Reconstituted feeds and feeds that have extra ingredients added should not be left in feeding administration set for longer than 4 hours – if feeding is required for a longer period, feed can be added freshly every 4 hours.
- Where the child is prescribed continuous feeding – the feeding set must be changed after 24 hours.
- Adhere to Aseptic Non Touch Technique (ANTT) throughout any procedure relating to enteral feeding.
- Prepare the correct volume of feed at the beginning of the feed.
- Ensure that the child is positioned at a 30-40 degree angle as a minimum; ensuring that their head is above the level of their stomach during feeding to avoid nausea, vomiting and reflux
- Flush the enteral feeding device on completion of the feed as per the child's care plan.
- Ensure child's oral hygiene is maintained eg tooth brushing/mouth care at least twice daily or as required to keep child's mouth healthy and moist and encourage regular dental checks

- ### 3.6 Troubleshooting guide (also see Appendix 5)

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Problem	Action
<p><b>Suspected infection of the stoma site.</b></p> <p>Possible causes:</p> <ul style="list-style-type: none"> <li>• Contamination of the tube/insertion site (e.g. poor hand hygiene )</li> <li>• Child scratching site.</li> <li>• Stoma leakage causing damage to surrounding skin</li> <li>• Child is immuno-compromised</li> </ul>	<p>Identify possible cause and manage appropriately</p> <p>Assess the child's general condition and seek medical advice if indicated.</p> <p>Obtain a swab of exudate from the stoma site for organisms and sensitivity.</p> <p>If an external fixator is present - check its position and adjust if necessary as per training.</p> <p>Continue cleaning the stoma site as per training – the type of dressing will depend on condition of the wound.</p>
<p><b>Over-granulation tissue</b></p> <p>Possible causes:</p> <ul style="list-style-type: none"> <li>• Trauma from friction around the tube</li> <li>• Poorly fitting tube. Excess moisture Infection</li> <li>• Reaction to foreign body e.g. allergy or hypersensitivity to enteral device</li> </ul>	<p>Identify cause and advise parent accordingly, dressing maybe needed to help treat over-granulation. See local practice guidelines for the treatment of over-granulation</p> <p>Ensure the external fixator is positioned as per training.</p> <p>If a low profile device is used – ensure the device fits correctly in the stoma tract and has minimal movement.</p> <p>If a tube device is being used ensure the tube is looped and taped securely and positioned above the stoma - alternate the position of tube following each feed to prevent granulation – Do not tape the device until formation of a stoma tract</p>
<p><b>Leakage at the stoma site after initial 72 hours post operatively</b></p> <p>Possible causes:</p> <ul style="list-style-type: none"> <li>• Stoma site stretched by the tube being pulled.</li> <li>• Occlusion within tube</li> <li>• Buried bumper</li> <li>• Tube migration due to peristalsis</li> <li>• Increased intra-abdominal pressure due to excessive coughing, or straining at stool.</li> <li>• Damage to the tube</li> <li>• Balloon deflation</li> <li>• The rate of feed is delivered too fast</li> <li>• Delayed gastric emptying</li> </ul>	<p>Identify and manage any underlying cause. Test leakage for pH to determine if it is gastric contents.</p> <p>Use a barrier film around the stoma site</p> <p>If the enteral device has an internal bumper/flange, readjust to ensure its position as per training.</p> <p>Balloon type device – check the water in balloon is the recommended amount.</p> <p>Avoid the device tubing being pulled accidentally. Check the position of device</p> <p>Treat any excessive coughing spasms/constipation.</p> <p>Do not clamp the tube when not in use. If there are any signs of tube damage – replace tube if able/appropriate or contact Robin Ward to agree management plan.</p>

Problem	Action
<p><b>Buried bumper</b></p> <p>Possible causes:</p> <ul style="list-style-type: none"> <li>Excessive tension between the inner and outer flange of the device</li> </ul> <p>Non-compliance with care plan</p>	<p>Seek advice from GP or Paediatrician if there are any signs of:</p> <ul style="list-style-type: none"> <li>Inability to infuse feeds with pump alarming</li> <li>Abdominal pain</li> <li>Peritubular leakage, leakage around tube</li> <li>Stoma infection</li> </ul> <p>Inability to advance the internal bumper/flange and rotate device 360 degrees</p>
<p><b>Blockage of enteral device</b></p> <p>Possible causes:</p> <ul style="list-style-type: none"> <li>Non-compliance with care plan</li> <li>Medications</li> <li>Buried bumper.</li> </ul>	<p>Identify and manage the cause of blockage.</p> <p>Ensure compliance and technique of enteral device management with regards to flushing the device and medication administration - review if identified.</p> <p>Flush with warm water, using a 50ml syringe with a push/pause technique.</p> <p><b>NB Do not use cola, lemon or pineapple juice.</b></p> <p>Massage the tubing between the fingers and thumb to help release the blockage.</p> <p>If unable to release the blockage, consider replacing with a new device as per training.</p> <p>If device is unsuitable for replacement contact Robin Ward for further management.</p>

Problem	Action
<b>Nausea, bloating, vomiting</b>	<p>Check the child's clinical condition.</p> <p>Check if the child is constipated – if so the child may require a change in diet/medications.</p> <p>Review timing of medication and enteral feed. Discuss with the Dietician re rate of feed.</p> <p>If the child with a jejunal device is vomiting milk feeds – check position of device. Consider slow gastric emptying. Seek advice from GP or Paediatrician</p>
<b>Diarrhoea</b>	<p>Obtain a stool sample for organism and sensitivity and virology, if appropriate</p> <p>Discuss with the Dietician as the feed may need to be reviewed. Review child's medications. Seek advice from GP or Paediatrician</p> <p>Parental education re-managing diarrhoea and vomiting as part of discharge plan</p>
<b>Constipation</b>	<p>Discuss with the Dietician with regard to the feed, amount of flush.</p> <p>Review medicines</p> <p>Child may require medication</p>

#### 4. CONSULTATION PROCESS

Name	Title	Date
Michelle Cumming	Operational Lead for Child and Family	24/03/22 23/06/22 09/08/22
Elsbeth Snowie	Clinical Effectiveness Facilitator	24/03/22
Justine Bell	Education and Practice Development Nurse	24/03/22
Gill John	Team Lead for CCNT	24/03/22

## 5. IMPLEMENTATION PLAN

Action	Responsible Person	Planned timeline
Policy to be placed on the Procedural Document Library	Education and Development Secretary/Administrative Assistant	Within 2 weeks following ratification
Email to all staff	Education and Development Secretary/Administrative Assistant	Within 2 weeks following ratification

## 6. MONITORING COMPLIANCE

To ensure that staff adhere to this policy and procedures compliance will be monitored by:

- Reviewing of care plans by team leader/acting up
- Supervision
- Oversight of practice by senior clinician/s
- Peer to peer review of practice
- Monitoring staff competencies
- Audit

## 7. EQUALITY IMPACT STATEMENT

Family Nursing & Home Care is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy document forms part of a commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

The Family Nursing & Home Care values underpin everything done in the name of the organisation. They are manifest in the behaviours employees display. The organisation is committed to promoting a culture founded on these values.

### Always:

- ✓ Putting patients first
- ✓ Keeping people safe
- ✓ Have courage and commitment to do the right thing
- ✓ Be accountable, take responsibility and own your actions
- ✓ Listen actively

- ✓ Check for understanding when you communicate
- ✓ Be respectful and treat people with dignity
- ✓ Work as a team

This policy should be read and implemented with the Organisational Values in mind at all times. See appendix 5 for the Equality Impact Assessment for these guidelines.

## **8. GLOSSARY OF TERMS**

### **Administration Set**

Plastic tubing used to connect the container to the feeding device

### **Aseptic Non-Touch Technique (ANTT)**

A unique and contemporary practice to reduce Healthcare associated infections using an aseptic technique

### **Aspiration**

A procedure used to determine the position of the end of the tube. Aspiration also refers to the accidental sucking in of food particles or fluids into the lungs

### **Balloon**

A water filled balloon holds some gastrostomy devices securely in the stomach

### **Bolus/Intermittent Feeding**

A prescribed volume of feed given slowly via a syringe at a specific time.

### **Buried Bumper Syndrome**

A rare complication which occurs when the internal plate has become buried in stomach wall.

### **Carer (caregiver)**

Someone other than a health professional who is involved in caring for a person with a medical condition

### **Continuous feeding**

Continuous feeds are the administration of a feed at a slower rate over a prolonged period.

### **Decanting**

Pouring feed from the original container into the administration set container

### **Enteral nutrition**

The provision of safe and effective nutritional support through the use of an enteral feeding device.

### **External Fixator**

A device that holds the enteral tube in place against the skin.

### **Flush**

Administering a small volume of water through the tube to clean it after you have used it to deliver your feed or medications.



**Gastro-oesophageal reflux disease (GORD)**

A common condition where acid from the stomach leaks out of the stomach and up into the oesophagus.

**Gastrostomy Tube**

Feeding devices which allow liquid feed, fluids and/ or medicines to be delivered directly into the stomach

**Gastrojejunostomy tube**

Enteral tube inserted through the abdominal wall which passes through the stomach into the jejunum for the purpose of nutrition support.

**Hypoallergenic**

Reduces the possibility of an allergic reaction

**Immuno-compromised**

Vulnerable to infection due to having an immune system that has been impaired by disease or a medical treatment

**Jejunostomy Tube**

A tube inserted directly into the jejunum (part of the small intestine)

**Naso-duodenal tube**

A polyurethane tube which is inserted via nose through the stomach and into either the duodenum or jejunum

**Naso-gastric**

A narrow tube that is passed into the nose and down the oesophagus into the stomach which allows liquid feed/medication to be delivered directly into stomach.

**Naso-jejunal tube**

A tube passed through the nose and down into the jejunum (the second part of the small intestine), thus bypassing the stomach and the duodenum.

**Orogastric (tube) feeding**

Nutrition support provided by a tube inserted through the mouth via the oesophagus into the stomach

**Over granulation**

Granulation tissue (natural healing process) beyond the amount required to replace the tissue loss as a result of skin injury or wound

**PINNT**

Patients on Intravenous and Naso-Gastric Nutrition Therapy

**PH Indicator Strips**

Used to confirm the feeding device is in the correct position by measuring the amount of acid in the stomach contents.

**Push/Pause technique**

A pulsatile flushing action to promote a turbulence effect within the tube.

**Single Use**

Use only once and then discard

**Single child use**

Can be used more than once on one specific child only.

**Stoma**

A surgically created opening into the body from outside the body.

**Venting**

Venting is letting the air (wind) out of the stomach.

## 9. REFERENCES

British Dietetic Association (BDA) (2019) *Guidelines for the Preparation and Handling of Expressed and Donor Breast Milk and Specialist Feeds for Infants and Children in Neonatal and Paediatric Health Care Settings*. Available at [2019sfuguidelines.pdf \(bda.uk.com\)](https://www.bda.uk.com/documents/2019sfuguidelines.pdf). Last accessed 27<sup>th</sup> January 2022

Guidelines and Audit Implementation Network (GAIN) (2015) *Guidelines for caring for an infant, child, or young person who requires enteral feeding*. Available at [4f08bb34-7955-49ea-adf1-9de807d3da66.pdf \(rqia.org.uk\)](https://www.rqia.org.uk/documents/4f08bb34-7955-49ea-adf1-9de807d3da66.pdf) Last accessed 26<sup>th</sup> January 2022

NHS Improvement (2016) *Nasogastric tube misplacement: continuing risk of death and severe harm*. Available at [Patient Safety Alert Stage 2 - NG tube resource set.pdf \(england.nhs.uk\)](https://www.england.nhs.uk/patient-safety/alerts/Patient-Safety-Alert-Stage-2-NG-tube-resource-set.pdf). Last accessed 26<sup>th</sup> January 2022

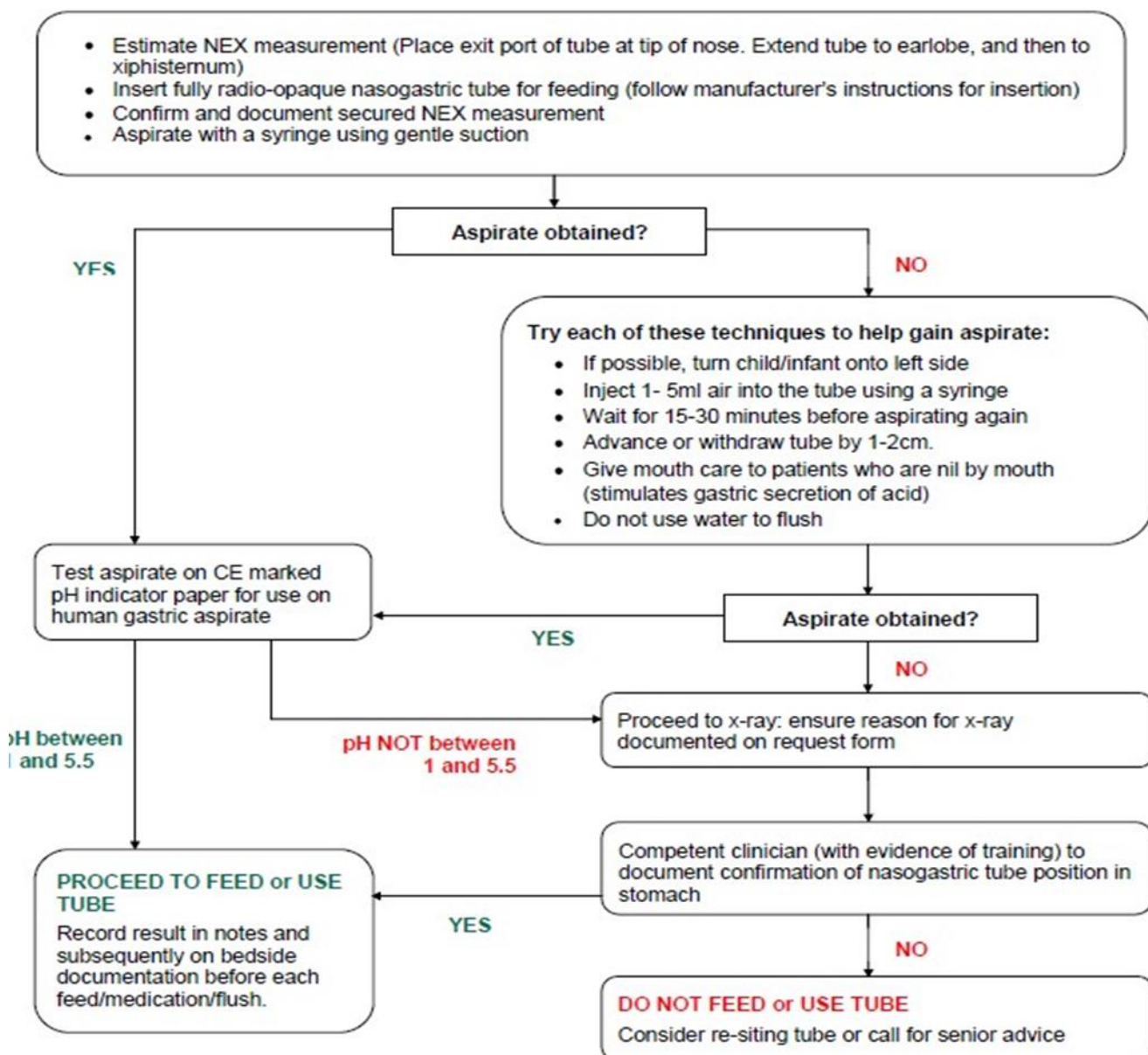
National Patient Safety Agency (NPSA) (2011) *Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants: supporting information*. NPSA/2011/PSA002. Available via <http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=129697&>. Last accessed 27<sup>th</sup> January 2022

**10. APPENDIX****Appendix 1 Hospital Discharge Information Form**

<b>Discharge information for a child following insertion of an enteral device</b>				
<b>Name</b>	<b>Address</b>	<b>Date of Birth</b>	<b>URN</b>	<b>Children's Community Nursing Team (CCNT) Contact Number</b> O1534 443626
<b>Child's Diagnosis/Reason for Enteral Device</b>		<b>Date of contact with CCNT</b>	<b>Name of CCNT Nurse contacted</b>	
<b>Date of discharge</b>	<b>Name of referring hospital nurse</b>	<b>Date and method of surgery</b>		
<b>Type of enteral device</b>		<b>Size</b>	<b>Length</b>	
<b>Replacement enteral device supplied YES/NO</b>	<b>Supplies to be provided before discharge</b>			
<b>Feeding Regimen</b>			<b>Child's Dietician Contact Details:</b> 01534 444660	
<b>Type of feed</b>	<b>Frequency of feed</b>	<b>Rate and volume of feed/flushes</b>	<b>Copy of Feeding Regime Supplied? YES/NO</b>	
<b>Feeding pump required YES/NO</b>	<b>Type of Feeding Pump required</b>		<b>Feeding pump provided Yes/NO</b>	
<b>Type of Training provided:</b>	<b>Competencies obtained</b>		<b>Copy of Competencies included on discharge YES/NO</b>	
<b>Date of review appointments</b>				
<b>Parents' guide booklet provided to parents YES/NO</b>			<b>Contact details completed YES/NO</b>	
<b>Community Dietician aware of discharge YES/NO</b>	<b>Referral to Speech and Language Therapist YES/NO</b>		<b>Aware of PINNT YES/NO</b>	

## Appendix 2 Decision Tree for NG Tube Placement Checks

### Decision tree for nasogastric tube placement checks in **CHILDREN** and **INFANTS** (NOT NEONATES)



A pH of between 1 and 5.5 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.

**Appendix 3 Risk Assessment for continuous overnight enteral feeding**

Risk	Control Measure
<p>Aspiration of feed</p> <p>Dislodgement of feeding Device</p> <p>Strangulation/entanglement due to feed tubing</p>	<p>Dietitian/Consultant to identify the need for overnight feeding i.e. severe reflux, vomiting, a condition requiring a slower rate of feeding</p> <p>Discuss with parents the potential risks with overnight enteral Feeding</p> <p>The child should sleep in the same room as the parents</p> <p>Position the child at an angle of 30 degrees or more during enteral Feeding</p> <p>Feed thickener/anti reflux medication should be prescribed if child has reflux</p> <p>Child should never be left unattended if awake during the night</p> <p>The feeding pump should be positioned at the side of the cot/bed with the administration set threaded through the bars rather than dangling over the top of the cot sides</p> <p>The feed tubing should be threaded through the inside of the child's pyjamas</p> <p>Regular review should be carried out for the need of continued overnight feeding</p> <p>Multidisciplinary Team assessment of the family's home needs should be undertaken</p>

## Appendix 4 Risk Assessment for administration of medicines via an enteral device

Risk	Control Measure
<p>Medicines may become unlicensed when given via an enteral feeding device.</p> <p>Not all medicines are suitable for administration via an enteral device.</p>	<p>Undertake a structured medicines review</p> <p>Always refer to a Pharmacist to check that the medicine prescribed is appropriate for enteral administration.</p> <p>Ensure that the Pharmacist has all the relevant information i.e. condition of the child, type of enteral feeding device, enteral feed, feeding regime and full medication list.</p> <p>Check with the Pharmacist/prescriber if the drug can be administered by any other method other than enteral device e.g. orally/ topically/ rectally.</p> <p>Prescribers must be informed that the medicine will be used outside the product license.</p>
<p>Drug interactions where more than one drug is prescribed.</p>	<p>Check with the Pharmacist if there are any interactions between drugs prescribed.</p> <p>Check with Dietician and Pharmacist how much flush needs to be given before, between and after medications. Be aware of fluid restriction and possible fluid overloading</p>
<p>Drug-patient interactions.</p>	<p>Check with a Pharmacist to ensure where the drug is absorbed and where the enteral feeding device is placed has been reviewed as this may have implications on how much of the drug is absorbed e.g. digoxin is absorbed in the stomach so should not be given via a jejunal route. The degree of clinical effect observed may be variable in this instance and the child's condition must be monitored</p>
<p>Drug-feed interactions</p>	<p>Check with Dietician and Pharmacist that the drug can be given with enteral feed prescribed e.g. does the feed need to be stopped for any specific length of time before/after drug administration?</p> <p>How much flush needs to be given between feed and medication?</p>

<p>Drug-tube interactions -some medicines e.g. Baclofen, if not administered correctly, may bind to the inner lumen of the tube which reduces amount of drug absorbed.</p>	<p>Check with Pharmacist how best to prepare medicine before administration e.g. does the medication need to be diluted to ensure the child receives the correct dose of medication?</p>
<p>Tube blockages may occur due to medications not being prepared, administered or flushed appropriately.</p>	<p>Use a pulsatile flushing action when flushing enteral device as it creates turbulence in the lumen of tube, removing debris and build - up of feed and medication.</p> <p>Ensure flushing with the recommended amount and type of water before/after each medication and feed.</p> <p>Will the drug increase likelihood of blockages e.g. medicines may be thick in consistency or prepared from granular formulations</p>
<p>Error in medication administration.</p>	<p>Check that the route of administration is clearly written on the relevant medication authorisation document.</p> <p>Ensure that the person administering the medicine is aware of the function of the enteral device i.e. DO NOT administer medicines via enteral devices that are used for aspiration or that are on free drainage.</p> <p>Check type of enteral device. Some enteral feeding devices have two lumens to enable simultaneous gastric aspiration and jejunal feeding. Ensure that the correct dedicated lumen is used for administration of medicines</p> <p>Always check position of the enteral feeding device and do not use if there are concerns.</p> <p>Nasogastric tubes should always have an aspirate between pH 1 – 5.5 (NHS Improvement, 2016) before flush/ medicines are administered.</p> <p>Ensure an enteral syringe is used to measure the amount and dose of medicines. These are purple and marked for enteral use.</p> <p>Use the appropriate size of enteral syringe to accurately measure the dose prescribed.</p> <p>Independently double check any dose calculations to ensure the correct dose is given, for example when calculating the volume of liquid to be given for a particular dose.</p>

## **Appendix 5 Surgical Tube Site Problems**

(As used and recommended by Gastroenterology Specialist Nurses at Southampton General Hospital)



Gastrostomy  
toolkit.pdf



## Appendix 6 Competency Document Nasogastric Tube Care and Use

**Note: Section F-K excludes Education staff**



### Competency Document for:

- Passing of a Nasogastric Tube (NG)
- Using a Nasogastric tube for Feed / Medication

### Background

These competencies are designed for the assessment of practice for passing and using a Nasogastric tube in paediatric patients. They are designed to assess staff from Bands 3 – 8

**This competency should be used in conjunction with:**

- The UHS Trust guidelines
  - Caring for Children with a Nasogastric Tube Whilst in Hospital
  - Paediatric Enteral Feeding

<b>Name</b>	
<b>Role</b>	
<b>Place of Work</b>	

## Supervised Practice

<b>Performance criteria essential for competent placement and use of an NG tube</b>	
<b>Learners Must:</b>	
A	Show an understanding of the UHS trust guidelines regarding the use of an NG tube
B	Demonstrate an in-depth knowledge of the gastro intestinal tract. Discussing where the NG tube should be placed and the possible consequences of a misplaced tube
C	Demonstrate correct handwashing technique prior to any contact with the patient
D	Demonstrate the ability to: <ul style="list-style-type: none"> <li>gain verbal consent from the child/family as appropriate</li> <li>prepare them for the appropriately for the procedure</li> </ul>
E	Demonstrates an awareness of who needs to be contacted in the community or the ability to make a referral to the appropriate team if the child is to go home with an NG tube
<b>Passing an NG tube (excluding Education staff). The learner Must:</b>	
F	Collect appropriate equipment to pass an NG tube for feeding or gastric decompression.
G	Demonstrate how to measure the Nose-Ear-Xiphisternum (NEX) measurement
H	Demonstrate how to position the patient to achieve correct placement and what additional techniques can be used to aid the passing of an NG tube
I	Demonstrate passing an NG tube with and without a guidewire.
J	Confirm the placement of the NG tube appropriately using pH paper and document appropriately (including tube size, NEX and initial pH)
K	Demonstrate securing the NG tube safely
<b>Feeding via an NG tube. The learner Must:</b>	
L	Collect the appropriate equipment for the feed and have a working knowledge of the feeding techniques (gravity bolus/pump bolus/continuous)
M	Demonstrate the correct method of tube checking (as per guideline) and document the pH and NEX measurement on the correct paperwork. For unregistered staff pH paper change must be verified by a registered member of nursing staff
N	Demonstrates safe delivery of feed and is aware of what to do if child becomes distressed.
O	Disposes of equipment appropriately when feed is finished and records amount in child's documentation
<b>Teaching. The learner Must:</b>	
P	Demonstrate an ability to teach parents to pass an NG tube
Q	Demonstrate an ability to teach parents to use an NG tube for feeds/medication
R	Demonstrate to parents what to do if they have problems with the NG tube
S	Be able to send the family home with appropriate supplies

## Performance Rating Scale: to be used during period of supervised practice

Level of Achievement	Grade
Cannot perform this activity satisfactorily to participate in the clinical environment	0
Can perform this activity BUT not without constant supervision and some assistance	1
Can perform this activity satisfactorily but requires some supervision and/or assistance	2
Can perform this activity satisfactorily without supervision and/or assistance	3
Can perform this activity without assistance and/or supervision with more than acceptable speed and quality of work	4
Can perform this activity satisfactorily with more than acceptable speed and quality of work and with initiative and adaptability to special problem situations	5
Can perform this activity with more than acceptable speed and quality, with initiative and adaptability and can lead others in performing this activity	6

Fearon (1998) *Assessment and Measurement of Competence in Practice*. Nursing Standard Feb 1998 Vol.12 No 22

## Record of supervised practice

Date	Criteria (letter A – S)	Self-assessment Rating	Assessors Rating	Assessors Signature	Assessors Comments

Photocopy this sheet in order to have more rows

## Sign off of Competency

I have assessed..... (Learners name) in the below criteria and in my professional opinion he/she is competent to carry out this role unsupervised

Criteria	Assessors Signature	Candidates Signature	Date
A			
B			
C			
D			
E			
F			
G			
H			
I			
J			
K			
L			
M			
N			
O			
P			
Q			
R			
S			

I ..... (Candidate) have been assessed, and feel happy to carry out the above criteria unsupervised. I understand that I am responsible for maintaining my competence and keeping up to date.

## Appendix 7 Competency Document Surgically-placed Enteral Feeding Tubes Care and Use



### Competency document for the care and use of surgically placed enteral feeding tubes for nursing staff in child health

#### Background

These competencies are designed for the assessment of practice for feeding babies and children via surgically placed enteral feeding tubes. They are designed to assess the entire clinical nursing work force (Bands 3 – 8).

Surgically placed enteral feeding tubes include:

- Gastrostomy devices
- Gastro-Jejunal devices
- Direct placement surgical Jejunostomy

This competency should be used in conjunction with:

- The appropriate patient / parent information booklets

<b>Name</b>	
<b>Role</b>	
<b>Place of Work</b>	

## Supervised Practice

Performance criteria essential for competent care and use of an enteral feeding tube. The learner MUST:	
A	Demonstrate correct hand washing technique prior to any contact with the patient.
B	Should be able to identify the type of enteral feeding tube.
C	Demonstrates the ability to gain verbal consent from the child or family as appropriate and the ability to prepare them for the appropriate procedure.
D	Demonstrates an awareness of who needs to be contacted in the community or the ability to make a referral to the appropriate team.
Care of feeding tubes. The learner MUST:	
E	Demonstrate how to care for stoma site.
F	Demonstrate knowledge of tube care – turning, advancing and balloon care.
G	Demonstrate knowledge of skin fixation methods and when this is required.
H	Demonstrate or explain what to do in an emergency.
I*	Demonstrate the ability to replace an enteral feeding tube appropriately and test its position.
	* Please note this skill is Band 4 and above
Use of feeding tubes. The learner MUST:	
J	Demonstrate knowledge and understanding of the correct position for a child having a feed.
K	Demonstrate the ability to identify the correct equipment required for giving an enteral feed – extension sets, syringes and giving set.
L	Demonstrates knowledge and understanding of priming and attaching equipment.
M	Demonstrates an ability to safely deliver feed, either bolus or continuous, and is aware of what to do if the child becomes distressed.
N	Demonstrate safe administration of medicines via an enteral feeding tube.
O	Be able to discuss and understand the concepts of free drainage and aspiration of an enteral feeding tube.
P	Demonstrate the appropriate administration of flushes for a variety of reasons.
Q	Confirm their ability to dispose of, clean and store equipment appropriately.
R	Demonstrate the appropriate use of patient documentation.
Teaching. The learner MUST:	
S	Demonstrate the ability to teach parents/ careers to feed using an enteral feeding tube.
T	Demonstrate the ability to teach parents/ careers to care for an enteral feeding tube.
U	Demonstrate the ability to introduce the parents to the emergency including kit and how to use.
V	Be able to send the family home with the appropriate supplies

## Performance Rating Scale: to be used during period of supervised practice

Level of Achievement	Grade
Cannot perform this activity satisfactorily to participate in the clinical environment	0
Can perform this activity BUT not without constant supervision and some assistance	1
Can perform this activity satisfactorily but requires some supervision and/or assistance	2
Can perform this activity satisfactorily without supervision and/or assistance	3
Can perform this activity without assistance and/or supervision with more than acceptable speed and quality of work	4
Can perform this activity satisfactorily with more than acceptable speed and quality of work and with initiative and adaptability to special problem situations	5
Can perform this activity with more than acceptable speed and quality, with initiative and adaptability and can lead others in performing this activity	6

Fearon (1998) *Assessment and Measurement of Competence in Practice*. Nursing Standard Feb 1998 Vol.12 No 22



[illegible]

FNHC  
Page 41 of 43

## Sign off of Competency

I have assessed ..... in the below criteria and in my professional opinion he/she is competent to carry out this role unsupervised

Criteria	Assessors Signature	Candidates Signature	Date
A			
B			
C			
D			
E			
F			
G			
H			
I			
J			
K			
L			
M			
N			
O			
P			
Q			
R			
S			
T			
U			
V			

I ..... (the candidate) have been assessed, and feel happy to carry out the above criteria unsupervised. I understand that I am responsible for maintaining my competence and keeping up to date.

## Appendix 8 Equality Impact Screening Tool

Stage 1 - Screening			
Title of Procedural Document: Policy and Procedures for caring for an infant, child or young person who requires enteral feeding			
Date of Assessment	2022	Responsible Department	CCNT
Name of person completing assessment	Lyn Vidler	Job Title	Deputy Sister CCNT
Does the policy/function affect one group less or more favourably than another on the basis of :			
	Yes/No	Comments	
• Age	Yes	Not suitable for over 18's or Neonates	
• Disability Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia	Yes	Learning disabilities and sensory impairment	
• Ethnic Origin (including hard to reach groups)	No		
• Gender reassignment	No		
• Pregnancy or Maternity	No		
• Race	No		
• Sex	No		
• Religion and Belief	No		
• Sexual Orientation	No		
If the answer to all of the above questions is NO, the EIA is complete. If YES, a full impact assessment is required: go on to stage 2, page 2			
Stage 2 – Full Impact Assessment			
What is the impact	Level of Impact	Mitigating Actions (what needs to be done to minimise / remove the impact)	Responsible Officer
Training to staff/parents looking after children who require Enteral feeding is carried out regularly by the CCNT. These children are also supported by the Child Development and Therapy Centre for their sensory and learning disability needs.		Delegation of care paperwork completed for outside organisations. Speech and Language therapy (SALT) involvement.	
Monitoring of Actions			
The monitoring of actions to mitigate any impact will be undertaken at the appropriate level			