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Troubleshooting Guidelines for Gastrostomy Tubes

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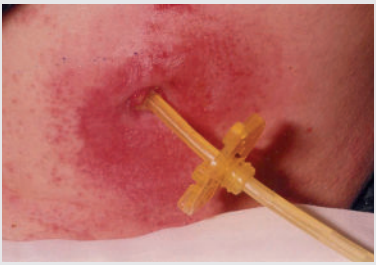
Stoma site is red & inflamed



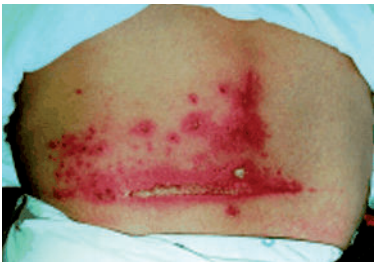
Nurses Intervention

(Non-qualified nurses/carers should follow steps 1-4. Contact the District Nurse/Community Children's Nurse or Nurse Specialist for advice regarding steps 5-8).

1. The stoma should be cleaned at least once daily using a mild soap and gauze.
2. It is advised that the patient should not bathe or immerse the area in water while the stoma is healing. The patient's normal bathing may recommence after two weeks, or as per local policy.
3. Meticulous hand hygiene and cleansing of the stoma is essential to minimise the risk of infection.
4. Always ensure the area is dried thoroughly afterwards to minimise risk of infection.
5. If the stoma site becomes red and inflamed, a swab of the site may be required for microbiological culture. Before this advise to increase the cleaning up to a maximum of eight times a day.
6. If a swab is taken, inform the GP, as antibiotics may be required.
7. If the gastrostomy site is infected with MRSA, Aquasept is recommended for cleansing.
8. The site will need to be re-screened for MRSA. If in doubt, contact the Infection Control Nurse.

Outcome: Prevent infection occurring.

Leakage from stoma site



Nurses Intervention

(Non-qualified nurses/carers should follow steps 1-4. Contact the District Nurse/Community Children's Nurse or Nurse Specialist for advice regarding steps 5-7).

1. Ensure the external fixator is snug to the skin and the tube is secure. The gastrostomy device should not be too loose or too tight, as either will allow for leakage of stomach contents.
2. Ensure the skin around the gastrostomy site is cleaned twice a day with soap and water, then dried thoroughly.
3. Cavilon spray/swab stick may be used to protect the skin (ensure the balloon inflation port is protected from the Cavilon during application).
4. Note when patient last had their bowels opened. Leakage may be due to excessive pressure in the abdomen.
5. Ensure patient is on an acid suppressing drug to reduce acidity of gastric contents (e.g. Lansoprozole, Ranitidine).
6. For balloon gastrostomy devices, check water volume in the balloon. Note volume in balloon and compare with recommended volume. Replace with recommended volume of water. Leakage may stop if the balloon is inflated a further 2mls - do not exceed manufacturer's recommended balloon fill volume.
7. Dressings can be applied to the stoma when leakage is excessive. An absorbent dressing is recommended (contact the nurse specialist or manufacturer representative for advice).

Outcome: Prevents leakage of gastric contents & excoriation of skin.

Potential pain and discomfort following tube insertion or change

Nurses Intervention

(Non-qualifiednurses/carersshouldseekadviceoftheDistrictNurse/CommunityChildren'sNurseor GP regarding pain control).

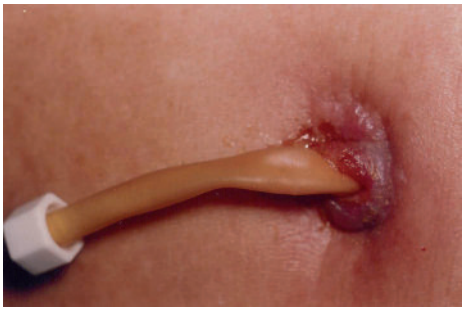
1. Each patient should receive strong analgesia immediately post procedure and for the following 24-48 hours depending on patient's pain experienced.
2. Pain assessment should be done regularly throughout the days following the tube insertion.
3. The use of moderate pain relief is advisable for the 48 hours post insertion. Patients will be monitored regularly for the first 72 hours in accordance with the NPSA recommendation.
4. After four to five days the patient should only experience mild discomfort from the tube. A patient who is experiencing severe pain needs urgent referral to the Doctor or Nutrition Nurse Specialist.
5. Following tube changes or gastrostomy changes, mild pain relief e.g. paracetamol may be helpful.

Outcome: Reduces pain.

Over granulation around the stoma site

Nurses Intervention

(Non-qualified nurses/carers should seek advice of the District Nurse/Community Children's Nurse or GP regarding over granulation).



1. The stoma site should be cleaned as indicated. Over granulation tissue can produce an exudate, which may require more frequent cleansing, up to eight times a day.
2. Ensure the gastrostomy device is not too loose or tight to the abdomen, both are potential causes of over granulation tissue.
3. Contact a Specialist Nurse on this field, regarding appropriate treatment. Treatments may vary according to local policies, if creams are required these will need to be prescribed by your GP.
4. Follow recommended guidelines on usage of creams.

Outcome: Ensuring the gastrostomy device is secure will prevent tube movement and reduce the incidence of over granulation. Treating the over granulation will reduce the risks of further complications.

Device displacement

Nurses Intervention

If displacement occurs within four weeks of gastrostomy formation

1. Stop the feed immediately.
2. For patients in the community urgently attend the Accident & Emergency department at your local hospital.
3. Contact the Nutrition Nurse Specialist or Gastro Registrar on call for immediate help and advice.

Nurses Intervention

If displacement occurs post four weeks of gastrostomy formation

1. Stop the feed immediately.
2. For patients in the community contact your District Nurse or Community Children's Nurse urgently, or attend the Accident and Emergency department at your local hospital.
3. Keep the stoma open by inserting a standard gastrostomy tube or, in an emergency, a Foley catheter through the stoma and tape in place.
4. Check position of the tube by aspirating gastric contents and testing with pH indicator paper.
5. If in any doubt about the position of the catheter, DO NOT USE! Keep patient nil by tube/mouth and refer to Nutrition Nurse Specialist/Gastro Unit/placement hospital. A Foley catheter should only be used as a temporary device and not as a replacement gastrostomy.
6. Keep the patient hydrated with IV/S/C fluids as required. For patients in the community, guidance regarding IV or subcutaneous fluid provision should be sought through GP, District Nurse or Hospital Specialist.

Outcome: Reduces pain.

Damaged device, connectors/extension set

Nurses Intervention

(Non-qualifiednurses/carersshouldseekadviceoftheDistrictNurse/CommunityChildren'sNurseorGP).

1. Spare connections/extension sets for in-patients should be obtained from the Nutrition Nurse Specialist/Endoscopy Unit or central stores.
2. Ensure patients at home have spare connectors/extension sets for balloon retention gastrostomy devices, also a spare device, or at least have direct access if required e.g. via District Nurse/Community Children's Nurse.
3. Replacement connectors/extension sets are available from the supplier. Seek advice from your Procurement/Stores department.
4. DO NOT rely on the hospital to provide spare connectors/extension sets for patients at home, as they may be unavailable.
5. If you are unable to repair a damaged device, contact your District Nurse/Community Children's Nurse/Nutrition Nurse Specialist/Gastro Unit or placement hospital.

Outcome: Prevent any delay in feeding the patient and unnecessary admission to hospital.

Potential absorption/ aspiration problems

Nurses Intervention

(Non-qualified nurses/carers should follow steps 1-3 then seek advice from the District Nurse/ Community Children's Nurse or GP).

1. Check feeding position/technique.
2. Ensure the patient is sat up during feeding and at least one hour post feeding (patient's upper body should be elevated 30-40 degrees).
3. Check when patient last had their bowels opened.
4. Check for other causes, e.g. infection, antibiotic therapy, etc.
5. Consider medication which increases gastric motility and prevents/reduces vomiting (discuss with specialist nurse/dietitian).
6. Contact dietitian for advice regarding the type or rate of feed.
7. If patient is at risk of aspiration they should be fed during the day when they can be closely monitored.
8. If the problem continues contact the Nutrition Nurse Specialist or GP for advice.

Outcome: Feed is delivered in a safe and effective manner without causing complications.

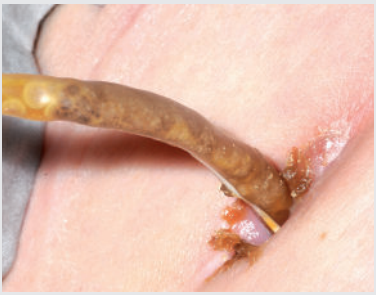
Pump alarming

Nurses Intervention

1. Check clamp is not on (if present).
2. Observe tube/giving set for kinks.
3. Ensure drip chamber is not overfilled (if present).
4. Refer to trouble-shooting guide provided with your pump.
5. If unable to resolve contact pump company representative.

Outcome: Prevent any delay in feeding the patient and unnecessary admission to hospital.

Tube blockage



Nurses Intervention

1. Always ensure the device is flushed with water as per the patient's feed regimen before and immediately after feeding, also before, in between each and after administering medications.
2. If the device becomes blocked try flushing with warm water. If blockage is evident in tube, massage tube at this point to try and disperse blockage.
3. Give the tube a reasonably firm flush.
4. Try flushing the tube with carbonated water.
5. Ask the GP to prescribe "Pancrex V". This contains pancreatic enzymes and helps to clear blocked tubes. Caution must be taken not to get this medication on the hands and skin.
6. Do not insert guidewires down the tube in attempt to unblock it as they may damage the tube or cause trauma to the patient.
7. If the recommended methods to unblock the tube have failed, contact the Nutrition Nurse Specialist/Gastroenterology Unit or District Nurse/Community Children's Nurse for further advice.

Outcome: Feed is delivered in a safe and effective manner without causing complications.

Problems with diarrhoea

Nurses Intervention

(Non-qualifiedstaff/carersshouldcontactthepatient'sDistrictNurse/CommunityChildren'sNurseorGP).

1. Observe any changes in bowel habits or existing problems with bowel.
2. If patient has diarrhoea, a stool specimen may need to be obtained for culture and sensitivity.
3. Check patient's medication, which could be contributing to diarrhoea, e.g. antibiotics, antacids, elixirs, etc...
4. If stool sample is negative, then antidiarrhoeals can be used. Consult GP/Hospital (Doctor)/ District Nurse/Paediatrician.
5. Always ensure good hygiene standards are maintained when handling the tube or delivering the feed.
6. Refer to dietitian - who may recommend a fibre feed.
7. If patient has gut atrophy (no enteral intake for 72 hours or more), the only way to overcome it is to persist with feed - antidiarrhoeals if cultures are negative.
8. If feed is administered as a bolus, consider reducing the flow rate, or using a feed pump.

Outcome: For patient to have regular/normal bowel movement.

Constipation

Nurses Intervention

(Nonqualifiedstaff/carersshouldcontactthepatient'sDistrictNurse/CommunityChildren'sNurseorGP).

1. Monitor bowel function regularly.
2. If patient is constipated, try extra flushes of water via the gastrostomy device. Advice on fluid volumes should be sought from the dietitian.
3. Contact the dietitian who will be able to advise on types of feed required.
4. If constipation persists, laxative medication may be required, contact GP or Paediatrician.

Outcome: Maintain regular bowel movements.

Patient observation

Patient is alert and motivated and carers feel that swallowing may have improved. Parents/carers report that the child's health has improved and the child is showing an interest in eating orally.

Nurses Intervention

(Non-qualifiedstaff/carersshouldcontacttheDistrictNurse,thechild'sCommunityChildren'sNurse,or the GP for advice).

1. Check when the Speech and Language Therapist (SALT) last saw the patient.
2. Telephone the relevant SALT department to discuss patient with the SALT. SALT will decide on appropriate follow-up.
3. If patient not known to SALT, initiate referral via GP/Paediatrician.

Outcome: Awareness of patient's improvement.

Notes

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