Derby City Council

MEDICATION POLICY

Children's Homes

People's Directorate
Children and Young People's Services

Additional guidelines to Medication Policy

1. Enteral Feeds (in line with AHH)
2. Enteral Meds (new)

Document History

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DERBY CITY COUNCIL

ADDITION TO CHILDREN'S HOME MEDICATION POLICY - LIGHT HOUSE

ADMINISTERING MEDICINES SAFELY VIA ENTERAL FEEDING TUBES

Reason for this review	New Guideline
Policy version/ Date	V1 10.09.19
Summary	Addition to DCC Administration of Medication policy 1. new route of administration of medication via enteral tube 2. new route of administration of feeds via enteral tubes
Policy links to	The guideline is an appendix and underpinned to the Derby City Children's Homes Medication policy https://www.proceduresonline.com/derbycity/homes/files/med_policy.pdf?zoom_highlight=medication#search="medication"). All processes in the full Children's Home Medication Policy must be followed
Relevant legislation	• The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • The Health and Social Care Act 2008 (Regulated Activities) (Amendments) Regulations 2015
Underpinning knowledge	• Care Quality Commission *Administering medicines safely via enteral feeding tubes* 2019 • NICE 2012 *Healthcare-associated infections: Prevention and Control in Primary and Community Care* 2012 • Department of Health (2008) The Health and Social Care Act: *Code of practice for Heath and adult social care on the prevention and control of healthcare associated infections and related guidance* • The National patient Safety Agency (NPSA) Patient Safety Alert: *Promoting safer measurements and administration of liquid medicines via oral and other enteral routes* March 2007 • https://www.bapen.org.uk/nutrition-support/enteral-nutrition/medications • White, R and Bradman, V (2006) *Handbook of Drug Administration via Enteral Feeding tubes*, first edition, Pharmaceutical press • http://newtguidelines.com/index.html
Target audience	• All Residential Child Care staff at level 2 and 3, Managers, Night Care Assistants and Senior Night Care assistants within the Light House short breaks residential unit for the administration of enteral feeds • Residential Child Care staff within the Light House short breaks residential Unit at Level 3 and above and Senior Night Care Assistants for the administration of enteral medication

This guideline policy is in addition to the DCC policy Medication Policy for Children's Homes that provides guidance on the administration via oral and topical routes. This addition provides guidance on administration via the enteral route for the

1. administration of medication
2. administration of feeds

as both the medication and feeds via enteral tubes are available via prescription only.

1.0 Introduction

1.1 The wrong route of administration of medicines, flushes or enteral feeds can cause serious harm to a young person and may even be fatal.

1.2 The aim of this guideline is to promote best practice by reducing the risks associated with 'health care associated infection' (HCAI) and to reduce the risk of wrong route of administration of medication and nutrition or feeds associated with enteral routes.

1.3 Within the Light House,

1.3.1 Level 3 RCCWs, Managers and Senior Night Care staff will be required to undertake the administration of medication via the enteral route

1.3.2 Level 2 and Level 3 RCCWs, Managers, Night Care assistants and Senior Night Care staff will be required to undertake the administration of feeds via the enteral route.

2.0 Executive Summary

2.1 This guideline is an addition to the Derby City Council Medication Policy in Children's homes relating to the Administration of Medication via oral and topical routes and the Administration of enteral feeds.

2.2 The guideline is required as appropriately trained and competency tested residential staff within the Light House short breaks residential unit are required to undertake enteral feeding and the administration of medicines vie enteral routes to enable the safe care of young people receiving residential short breaks.

2.3 This guidelines set out the actions required to reduce the risks of wrong route administration of enteral medication or enteral feeds.

2.4 All medication and feeds will be prescribed for the young person and will be recorded on the MAR sheet. Administration of medication and feeds will be recorded in line with DCC policy as described in the Administration of medication policy.

3.0 Training

3.1 Enteral feeds, flushes and medication can only be administered by staff who are appropriately trained and competent. The required training will constitute DCC Administration of Oral Medication training, with reference to this policy as an

addition for Light House residential staff. Staff will also be required to have completed gastrostomy and nasogastric training and to be assessed as having child specific competency.

3.2 Gastrostomy, nasogastric training and child specific competency testing will be provided by a commissioned health service. The training will comprise of taught sessions, workbooks and observations of practice culminating in observed child specific competency assessments both in giving medication and feeds down enteral tubes.

3.3 It will be the responsibility of the health training provider to ensure the competency of social care staff. It is the responsibility of social care managers to ensure that all staffs' training and competencies are up to date and to escalate any competency or other training issues to the health training provider.

4.0 Guidance Statement – Administration of medication via enteral tubes

The administration of medicines via enteral feeding tubes is likely to be out of the licensed route of administration as stated in the medicines Act 1968. Prescribers may use licensed medicines for indications, doses or routes outside the terms of the product license based on their clinical judgement. Care staff who administer medication, flushes or feeds via the enteral routes must be aware of and follow this guidance and Derby City Council's children's medication policy.

This guidance provides information to ensure all aspects of the national guidance is incorporated at a local level, to raise awareness of best practice and to act as a resource tool for staff providing care.

- ENFit compatible syringes must be used to measure liquid medicines, feeds and enteral flushes.
- ENFit compatible bottle adapters must be used with an ENFit compatible syringe to withdraw liquid medicines from medicine bottles.
- Enteral feeding tubes and administration/extension sets must not contain ports nor have connectors that can be connected to intravenous syringes or paraenteral lines.
- Three way taps must never be used on an enteral feeding system.
- ENFit oral/enteral syringes used for oral administration or measuring liquid medicines must be single use only.
- Large ENFit enteral syringes used for enteral administration must be single use only.
- The person who prepares the medication must be the person who administers the medication to the young person.
- All enteral feeding sets and syringes must be clearly labelled 'enteral' or colour co-ordinated purple.
- Medication drawn up into an oral syringe or an ENFit syringe or measured into a graduated medicine pot must be administered immediately.
- Medication prescribed for young people with enteral feeding tubes must be rationalised by the prescriber to the least number of administration episodes possible without compromising patient care.

- In the residential unit the feed administration/giving set must be changed every 24 hours. It must be labelled stating the date and time it was set up.

5.0 Administration of medication

5.1 The prescriber (eg. GP) must clearly specify on the prescription that the medication is for enteral administration.

5.2 If the enteral route is not specified the medication must not be administered until the prescriber has been contacted and route of administration of medication has been confirmed. Thus clinical responsibility for administering medication in this way lies with the prescriber.

5.3 The prescriber will be responsible for liaising with the pharmacist to review the prescription and establish if licensed liquid medicine formulations are available. If a licensed preparation is not available, then the pharmacist may recommend crushing or dispersing tablets, opening capsules or manufacturing a suspension for an individual young person.

5.4 The medication must only be administered to the young person by the person who prepared it.

5.5 The medication must be discarded if:

5.5.1 The administration process is interrupted at the point of administration

5.5.2 Medication has been left unattended in a graduated medicine pot or oral or enteral syringe.

5.5.3 Inform the prescriber if this happens so a decision can be made about the medication.

5.6 Preparation of oral drugs which are not commercially available as a liquid formulation

5.6.1 The alteration of medical formulations via enteral tubes eg. Crushing tablets, opening capsules is usually outside the license the drug and may alter the handling of the drug. Some drugs are not suitable for crushing (see table 1)

Table 1 – drugs not suitable for crushing

Formulation/class of drug	Comments
Enteric coated (EC)	If crushed, enteric coated tablets break up into small pieces that clump together when moistened and can clog the feeding tube
Modified release (MR)/ Sustained release (SR)	Crushing these drugs may result in abrupt high or low peaks of the drug which can be dangerous to a patient, especially if the drug has a narrow therapeutic range (?X?)
Buccal/sublingual	Designed to avoid the GI tract and first pass metabolism. The doses may be low and may be insufficient if given via an enteral tube

Chewable tablets	Designed to be partially absorbed in the mouth, not all the drug will be absorbed if crushed
Cytotoxics and hormones	Potential risk to staff from aerosols from particles

5.6.2 A tablet crusher/or pestle and mortar must be used when crushing tablets. This will ensure the correct dose is given. The tablet crusher/pestle and mortar must be cleaned between uses. Only ceramic pestle and mortars are to be used.

Table 2 – type of water to use

YP group	Enteral tube	Recommended water for flushes/mixing with tablets or capsules
Intra-gastric	Intra-gastric feeding tube	Freshly drawn drinking tap water
Immuno-compromised	Intra-gastric and Intra-jejunal feeding tube	Cooled boiled freshly drawn drinking tap water
Intra – jejunal	Intra-jejunal feeding tube	Cooled boiled freshly drawn drinking tap water

5.6.3 Store any unused water for 24 hours only. Store in a clean lidded container.

5.6.4 Wash the container daily in hot detergent water. Rinse and dry with paper towel.

5.6.5 Do not contaminate the water by dipping in used syringes and other equipment.

5.7 Volume of water to be used

5.7.1 The volume of water to be used will depend on the individual patient and their individual fluid requirements and will be calculated by the dietician. Sufficient water flushes to flush the drug out of the delivery system will be required.

5.7.2 If the volume of fluid is not a concern, a minimum of 10-15ml of water should be used to disperse each tablet and to mix in with the crushed tablet or powder from capsules.

5.8 If more than one medicine is given, the extension set should be flushed with 2-5 ml of water between each medicine to prevent drug interactions.

5.9 If a medicine is due at the same time as a feed, always give the medicine before the feed unless other instructions are given.

5.10 After giving a medicine, flush the extension set with 20ml of water to ensure all medicine is given. Volume of flush may be adjusted depending on the young person's fluid needs, this will be indicated on the Feed plan.

6.0 Administration errors

6.1 Any errors in the administration of medication via the enteral route must be reported following DCC procedures laid out in the administration of Medication policy.

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7.0 Guideline statement Administration of enteral feeds

7.1 This guidance is for residential staff at the Light House who are using enteral feeding equipment. It aims to promote best practice by reducing the risks associated with 'health care associated infection' and to reduce the risk of wrong route of administration associated with the use of enteral syringes for administration of feeds an flushes via the enteral route.

7.2 Enteral feeding is generally required when a child is unable to meet their nutritional and/or hydration needs orally.

7.3 All young people requiring enteral feeding must have an up to date feeding plan prepared by the dietician. This must be followed by all staff administering feeds.

8.0 Enteral feeding devices

Type of enteral feeding device	Placement and use	Indications	Potential risks
Gastrostomy devices Percutaneous Endoscopic Gastrostomy tube (PEG) Button/low profile device Non-balloon gastrostomy tube Balloon gastrostomy tube	Feeding devices which allow liquid feeds, fluids and/or medicines to be delivered directly into the stomach Suitable for bolus/continuous feeds Venting and aspiration purposes An initial gastrostomy tube can be inserted endoscopically, radiologically, surgically or percutaneously in a surgical theatre environment	Long term inability to maintain oral intake	Accidental dislodgement Tube migration Granulation at stoma site Infection Buried bumper (internal plate has become buried in stomach wall) Blockage
Jejunostomy Balloon button device Tube deice G tube with external fixator	Long term use Enteral feeding device inserted surgically into jejunum Continuous feeds only		

9.0 Enteral Feeds

9.1 There are two types of feed:

9.1.1 Ready to use feeds which have been specifically prepared and pre-packed. These are ideally administered with a closed system. Reconstituted feeds are feeds which come in a powdered form and need to be prepared before use.

9.1.2 All feeds must be used within the marked expiry date.

9.1.3 Store ready to use feeds in a cool, dry place out of direct sunlight.

9.1.4 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.

9.1.5 Where a feed has been decanted into a feeding administration set, this should be administered within 4 hours.

9.1.6 Avoid wastage where possible. Once opened, the remaining ready to use feed should be labelled with date and time it was opened, refrigerated and used within 24 hours.

9.1.7 Reconstituted feeds should be made up with hot water of at least 70 degrees Celsius (boil the kettle and leave to cool for no longer than 30 minutes).

9.1.8 The administration of liquidised food is not currently recommended by the British Dietetics Association due to the risk of nutritional inadequacy, likelihood of tube blockage and the risk of gastric infection.

10.0 Administration of enteral feeds

10.1 Prior to the administration of any enteral feeds, every young person must have an up to date dietician plan and all feeds must be recorded on MAR charts.

10.2 Clean non-touch technique must be practiced throughout any procedure relating to enteral feeding.

10.3 It is important that the child is established on a feeding regimen which meets their nutritional and dietary requirements. The feeding method and prescription is indicated by the dietician in consultation with the family.

10.4 Ensure that the child is supported at least a 30-40 degree angle during feeds to ensure that their head is above the level of their stomach to avoid nausea, vomiting and reflux.

10.5 The feed should be stopped and medical attention sought if there are any signs of shortness of breath, paleness, vomiting or persistent coughing as the child may have aspirated.

10.6 Accurate records must be kept including the date/time of the feed, volume and type of feed administered, and if the feed was tolerated.

10.7 The enteral feeding device should be flushed on completion of the feed as per the child's care plan.

11.0 Types of enteral feeding:

11.1 Continuous using a pump. Continuous feeds are the administration of feeds 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.

11.2 Intermittent and/or Bolus feeding. This 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. Not all young people can tolerate bolus feeds, they must be administered following the child's dietician care plan.

11.3 Jejunal/duodenal feeds. These are always administered over a longer, slower period of time.

TROUBLE SHOOTING GUIDE FOR ENTERAL DEVICES

PROBLEM	ACTION	RATIONALE
Dislodgement of stoma enteral device due to: Accidental dislodgement Tube damaged/perished Balloon type devices where the balloon has deflated or burst	Follow child's care plan regarding parental advice/action in the event of a dislodged device. Replace a new enteral device immediately if training provided. If not, or unable to insert new enteral device – cover stoma with clean gauze and tape and go to hospital immediately. If dislodgement has caused trauma to stoma site, the child must be taken to hospital to have replacement device position checked. Dislodged device should be kept for inspection.	Stoma site may close quickly. To keep stoma site clean.
Suspected infection of the stoma site Possible causes: Contamination of the tube/insertion site (eg. Poor hand hygiene) Child scratching the site Stoma leakage causing damage to surrounding skin Child is immune-compromised	Identify possible cause and manage appropriately Assess the child's general condition and seek medical advice if indicated. Continue cleaning the stoma site using the correct dressing depending on the wound/site.	To avoid further infections To ensure effective treatment
Over granulation of tissue Possible causes: Trauma from friction around the wound Poorly fitted tube Excess moisture Infection	Identify cause and inform parents. Dressing may be needed.	Correct underlying cause of over-granulation

Blockage of enteral device Possible causes: Non-compliance with care plan Medications Buried bumper	Identify and manage the cause of blockage Ensure compliance and technique of enteral device management with regards to flushing the device and medication administration – review if identified Flush with warm water using a 50ml syringe with a push/pause technique Do not use cola, lemon or pineapple juice Massage the tubing between the fingers and thumb to help release the blockage. If unable to release the blockage, follow care plan regarding replacement of the device or consult hospital for further advice.	To prevent further blockages occurring Push/pause technique when flushing causes a turbulence effect which prevents adherence of any contents to inner tube Acidic juices worsen blockages.
Nausea, bloating, vomiting	Check the child's clinical condition Check if the child is constipated. If so, inform parents or administer appropriate prescribed laxative medication.	To ensure the child is not acutely unwell. Constipation can cause symptoms of nausea/vomiting.

12 Nasogastric feeding and administration of medication

12.1 Nasogastric Tube (NGT) is a thin soft tube passed through a child's nose, down the back of the throat, through the oesophagus and into the stomach.

12.2 Prior to accessing a NGT for any reason nursing staff members must ensure that the tube is located in the stomach. Coughing, vomiting and movement can move the tube out of the correct position.

12.3 The position of the tube must be checked:

- Prior to each feed
- Before each medication
- Before putting anything down the tube
- If the child has vomited
- 4 hourly if receiving continuous feeds

12.4 To check the position of the tube staff members need to have prepared the following equipment:

- pH test indicators;
- Enteral/oral syringe – 5ml – 20ml for aspiration;
- Gloves

12.5 Procedure:

1. Attach a 10-20ml oral/enteral syringe to the enteral tube in the child
2. Aspirate minimum 0.5 - 1ml of gastric content (or sufficient amount to enable pH testing). Consider the "dead space" in the tubing.
3. Utilising pH indicator strips a reading of between 0-5 should be obtained and documented.

12.6 Some medications and formulas may affect the pH reading. If the child is receiving a medication which is known to alter pH readings this should be clearly recorded on the MAR chart.
If a reading greater than 5 is obtained, placement of the tube is questionable and it should not be used until the position of the tube is confirmed.
If a reading greater than 5 is obtained leave for up to 1 hour and try aspirating again. Small-bore tubes can be difficult to aspirate therefore the following are suggested techniques to try enhance the ability to obtain aspirate:

1. Turn the child onto their side. This will allow the tip of the tube to move to a position where fluid has accumulated
2. Using a 10-20ml oral/enteral syringe insufflate 1-5ml of air into the tube. This may move the tube away from the wall of the stomach. It will also clear the tube of any residual fluid. If a child belches immediately following air insufflation, the tip of the tube may be in the oesophagus
3. Wait for 15-30 minutes. This will allow fluid to accumulate in the stomach and try aspirating again.
4. If it is safe to do so and the child is able to tolerate oral intake consider providing them with a drink and attempt aspirate in 15-30minutes
5. If no aspirate obtained, advance the tube by 1-2 cm and try aspirating again
6. If aspirate not obtained discuss with family or seek medical assistance.