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An audit of Trust-specific Enteral Feeding Guidelines

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Enteral feeding is defined as artificial nutritional support which is given enterally via a tube into the gut. To ensure that nutrition support is provided efficiently and effectively there must be standard policies and procedures, which are locally accepted, in place within an organisation[1–3]. Parenteral and Enteral Nutrition Group standards[4] determine that all nutrition and dietetic services have written policies and procedures on the provision of nutritional support both within the hospital and the community.

In 2003, the Trust Enteral Feeding Group developed Enteral Feeding Guidelines (EFG), with the aim of acting as a reference and teaching resource for the dietetic department, nursing and medical staff throughout the trust. The objectives of the audit were to assess compliance and understanding of the EFG and to highlight any aspects of practice where training or changes in practice were necessary.

Data was collected by dietetic and nursing staff during a 10-week period, between 23 March 2006 and 30 May 2006. Thirty-eight episodes of care involving patients receiving enteral feeds were included in the audit. Of these *n* 27 (71%) were nasogastric, *n* 1 (3%) nasojejunal, *n* 8 (21%) gastrostomy and *n* 2 (5%) jejonostomy. Results of thirteen EFG standards audited are shown in the Table.

Standards audited	Yes (%)	No (%)
1. NG/NJ tube marked with red pen	50	50
2. Length of the NG/NJ measured	54	46
3. Length of the NG/NJ recorded	46	54
4. pH tested at least daily	39	61
5. pH documented	29	71
6. Time and date recorded on feed bag	13	87
7. Less than 24 h since the feed was changed	71	29
8. Giving set changed in last 24 h	66	11*
9. Correct amount of feed given to patient	63	37
10. Over or under prescribed feed	29% under	8% over
11. Correct type of feed given	89	11†
12. Single-use syringe	71	29
13. 50 ml syringe used	87	13

* 18% changed but not documented, 5% not documented; † 11% not completed.

Compliance with many standards was poor. Least compliance was with date and time documented on feed bag, best compliance was with correct feed being given against dietetic prescription. A recurring theme was poor documentation; in many cases pH had been tested or length of tube measured, but not recorded.

The EFG have been revised and rewritten as a result of the audit and in light of recent NHS patient safety alerts[5,6]. A trust-wide EFG teaching tool and daily NG feeding documentation and check list have been produced. The trust-wide use of lilac coloured syringes and Medicina indicator pH strips has been introduced. The audit will be repeated in Spring 2008.

1. British Dietetic Association (1991) National Professional Standards for Dietitians. Birmingham: BDA.
2. Elia M, Cottee S, Holden C, Micklewright A, Pennington C, Plant J, Shaffer J, Wheatley C & Wood S (1994) Enteral and Parenteral nutrition in the community. BAPEN Working Party Report. PO Box 922, Maidenhead, Berks., SL6 4SH.
3. Silk DBA, Cottam TK, Neilson MS, Elcoat C, Fawcett H, Furness KM, Howard JP, Lennard Jones JE & Plester CE (1994) Organisation of nutritional support in hospitals. BAPEN Working Party Report. PO Box 922, Maidenhead, Berks., SL6 4SH.
4. British Dietetic Association, Parenteral and Enteral Nutrition group (1996) Dietetic Standards for Nutritional support. Birmingham: BDA.
5. National Patient Safety Agency (NPSA) Alert (2005) Reducing the harm caused by misplaced nasogastric feeding tubes. www.npsa.uk/advice
6. National Patient Safety Agency (NPSA) Alert (2007) Promoting safer measurement and administration of liquid medicines via oral and other enteral routes. www.npsa.uk/advice