CRITICAL ENTERAL TUBE MANAGEMENT GUIDELINES FOR PATIENTS IN THE RCNIC

Date: 6/2005

Approval:_____

PURPOSE:

To provide a systematic, standardized, multidisciplinary approach in the care and management of the patient with a critical enteral tube.

OBJECTIVE:

To effectively and safely care for and manage a patient who has a critical enteral tube. A critical enteral tube is defined by the medical/surgical team as a necessary structure not to be manipulated in order to maintain a patent postoperative site.

PERSONEL:

RN
MD
PHARMACY
HUC
PCA
PCF
RT
Developmental Care Specialist

EQUIPMENT:

Critical Enteral Tube Sign
Halo for Intubated Patient
Critical Enteral Tube Label

PROCEDURE:

1. Staffing Ratios
   a. 1:1 nurse to patient staffing during the first 48-72 hours of the postoperative period
   b. 1:1 nurse to patient staffing until follow up evaluation and operative site is not deemed "Critical" by the attending physician
   c. Any deviations from 1:1 staffing ratio must be approved by the medical team
2. The need for "Critical" status will be assessed, discussed, and documented (in the plan of care) during rounds each day.
3. Sign placed at bedside "Critical Enteral Tube: Do not manipulate or replace enteral tube without physician order and "Page (identified service responsible for critical enteral tube management, such as surgery, ENT) at this phone/pager number" with any emergencies, concerns, or problems".
4. Enteral tube will be clearly identified as "CRITICAL" with a "critical enteral tube label" on the actual tube.
5. Measure and document placement of enteral tube at least every four hours. Notify physician or practitioner if there are any changes in enteral tube placement or patency.

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6. Infant should be kept in a semi-upright position with HOB elevated at 45 degrees. The patient's head should be supported to prevent neck extension.
7. Maximize sedation and pain control.
    a. Assess and document infant's comfort level at least every 4 hours and prn using the NIPS
    b. Paralytics may be used **only if** absolutely necessary (rarely used after 24 hours post-op). Necessity for continued use of paralytics must be assessed and addressed on an ongoing basis.
8. If intubated, ETT must be taped separately from enteral tube and a "halo" should be used to support ventilator tubing. Maximum suctioning depth must be identified and documented in patient orders/IPOC and on the bedside card by RT.
9. Deep suctioning of the oropharynx/nasopharynx and esophageal area should be avoided.
10. Upon admission, including post-operative admission, the infant must be placed on a bedscale for daily weights. Daily weights should be done with a minimum of 2 caregivers. Daily weights can only be deferred by the medical staff.
11. Infant may not be held during the immediate postoperative period (first 48-72 hours post-surgery).
12. After the immediate post-operative period, infant may be held only with a physician order.
13. An RN or RT will provide continuous observation and assessment with documentation of activity level and tolerance of care.
    a. Activity level assessment and observation will include a developmental consult and/or a NIDCAP observation if applicable, with a clearly defined and documented developmental plan of care.
14. Individualized needs of patient clearly identified in the patient orders/IPOC. These needs will be based on patient's gestational age using a family-centered care approach, including but not limited to education about the following: family participation in care, diagnosis and treatment, needs and criteria for discharge, and activity level ..
15. Visual picture(s) of defect and post-operative site with information will be located in the patient's chart.