#69 - PROVIDING ENTERAL FEEDINGS (Partner Check-Off)

I acknowledge I have physically practiced and successfully learned the following skill(s):

Student: _____Date: _____

	P1	P2	P3	Comments
1. Verified the health care provider's orders. Checked the patient's baseline weight. Reviewed lab results.				
2. Gathered the necessary equipment and supplies.				
3. Performed hand hygiene, and provided for the patient's privacy.				
4. Introduced self to the patient and family.				
5. Identified the patient using two identifiers. Compared these identifiers with the information on the patient's identification bracelet.				
6. Asked the patient for any food allergies, and explained the procedure to the patient.				
7. Applied clean gloves.				
8. Auscultated for bowel sounds, and assessed abdomen. Placed the patient in the high-Fowler's position, or elevated the head of the bed to at least 30 degrees. If the patient must remain supine, placed him or her in the reverse Trendelenburg position.				
9. Obtained the prescribed formula: a. Verified the correct formula, and checked the expiration date. Noted the condition of the container. b. Administered the formula at room temperature.				
10. Prepared the formula for administration: a. Used aseptic technique. b. Shook the formula container well. Cleaned the top with an alcohol swab before opening it. c. If using an open system, poured the formula from the can into the administration bag. Hung the bag and primed the tubing. For closed systems, connected the administration tubing to the container. Ensured correct tubing was used.				
11. Verified tube placement. Checked the gastric residual volume before				

each bolus for intermittent feeding, or every 4 to 6 hours for continuous feeding. a. Drew 10 mL to 30 mL of air into a syringe, and connected the syringe to the end of the feeding tube. b. Injected the air into the feeding tube. Pulled back slowly on the plunger, and aspirated the entire gastric contents. Observed the appearance of the aspirate, and noted its pH. c. Noted the volume of aspirate, and returned the aspirated contents to the stomach unless the volume exceeded 250 mL, or proceeded according to agency's policy. d. Flushed the tubing with 30 mL of water.				
12. Traced the tube to its point of origin. Labeled the tubing at a site close to the patient and at a site close to the source when there are different access sites or several bags. Labeled the administration set: "Tube feeding only". Checked vital signs immediately after making any connection per organization's practice.				
13. Labeled the bag with the tube-feeding type, strength, and amount. Included the date, time, and initials. Changed the bag every 24 hours.				
14. Continuous or intermittent feeding with feeding bag using a pump: a. Pinched the proximal end of the feeding tube, removed the cap, and attached it to the tubing. Did not force connections, and avoided workarounds per the organization's practice. b. Traced tubing or catheter from the patient to point of origin (1) before connecting or reconnecting any device or infusion, (2) at any transition (e.g., new setting), and (3) as part of the hand-off process. c. Checked vital signs immediately after making any connection per the organization's practice. d. Set the infusion rate by adjusting the roller clamp on the tubing, or attached the tubing to the feeding pump. Allowed the bag to empty gradually over 30 to 45 minutes. e. Gradually advanced the rate of tube feedings, as ordered. f. Capped or clamped the end of the feeding tube used for intermittent feeding when not in use.				
15. After medication or formula administration, cleared the tube by flushing with sterile water using the lowest volume needed.				
16. Rinsed the bag and tubing with warm water whenever feedings were interrupted. Used a new administration set every 24 hours.				
17. Helped the patient into a comfortable position, and made sure the head of the bed remained elevated at least 30 degrees.				
18. Placed the call light within easy reach, and made sure the patient knew how to use it to summon assistance.				

19. Raised the appropriate number of side rails and lowered the bed to the lowest position.				
20. Disposed of used supplies and equipment. Left the patient's room tidy.				
21. Removed and disposed of gloves, if used. Performed hand hygiene.				
22. Documented and reported the patient's response and expected or unexpected outcomes.				

S = Satisfactory **U** = Unsatisfactory **NP** = Not Performed *=Must Perform to Pass

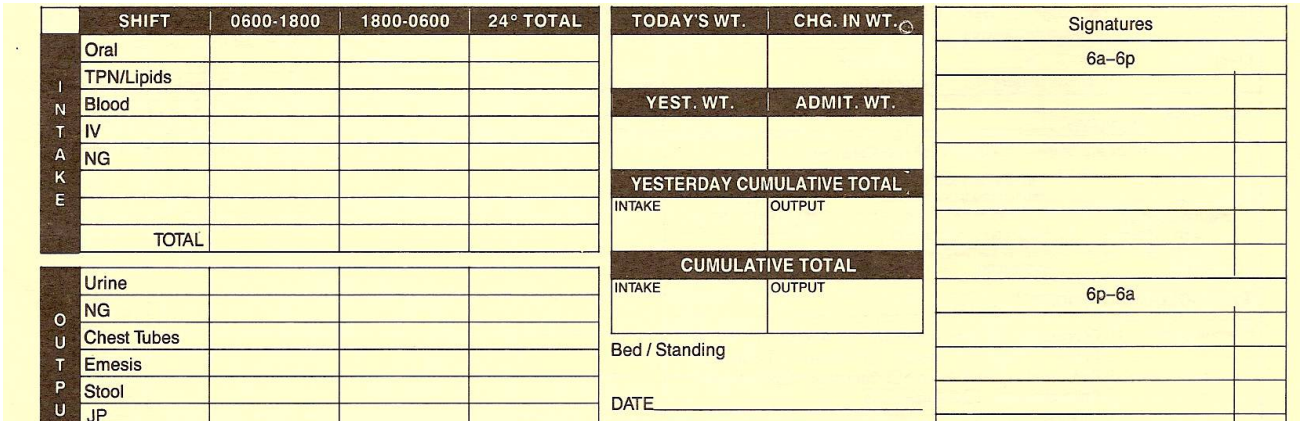
By signing below I acknowledge that I witnessed the skill performed and the student successfully passed the skill.
Practice 1: Evaluator:_____ Signature:_____

Practice 2: Evaluator:_____ Signature:_____

FINAL Student Evaluator:_____ Signature:_____

CHARTING CRITERIA: Verifies tube placement, type of formula given and amount, amount of residual obtained, any signs of intolerance to feeding. Documents on Graphics and I&O..

TIME	INTERDISCIPLINARY NOTES



	SHIFT	0600-1800	1800-0600	24° TOTAL
INTAKE	Oral			
	TPN/Lipids			
	Blood			
	IV			
	NG			
	TOTAL			
OUTPUT	Urine			
	NG			
	Chest Tubes			
	Emesis			
	Stool			
	JP			

TODAY'S WT.	CHG. IN WT.
YEST. WT.	ADMIT. WT.
YESTERDAY CUMULATIVE TOTAL	
INTAKE	OUTPUT
CUMULATIVE TOTAL	
INTAKE	OUTPUT

Bed / Standing

DATE_____

Signatures
6a–6p
6p–6a

Use this scenario for ICP – Feeding Self Care Deficit
Mr. Hankins was admitted 2 days prior from a long term care facility after suffering from a stroke. Mr. Hankins was unable to pass a swallow study and a nasogastric feeding tube was placed to provide nutritional support. Mr. Hankins has not been able to chew food after the stroke due to cognitive impairment. A feeding schedule based on patient tolerance still needs to be established.

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