Percutaneous Endoscopic Gastrostomy (PEG) Referral and Placement Clinical Guideline

V1.0

October 2018
1. Aim/Purpose of the Guideline

1.1. The aim of these guidelines is to standardise care for both inpatient and outpatients who require Percutaneous Endoscopic Gastrostomy (PEG) feeding tube insertion.

1.2. These guidelines provide information on:
- Referral process for both inpatient and outpatients
- PEG assessment
- Immediate pre- and post-procedure care
- Using the PEG tube and ongoing care and management
- Discharge

1.3. By ensuring that patients are appropriately referred and assessed this reduces any associated risk of complications and cancellations and ensures that the procedure is appropriate.

1.4. The document applies to all health care professionals involved with adult patients requiring PEG.

1.5. The document should be read in conjunction with the following Trust Policies:
- Policy for Consent to Examination or Treatment
- Discontinuation Of Antiplatelet And Anticoagulation Medications
- Cardiology Anticoagulation Clinical Guideline
- Management of Adult Patients with Diabetes Mellitus during Surgery or Elective Procedures
- Clinical guideline for the administration of drugs via enteral feeding tubes
- Clinical guideline for troubleshooting gastrostomy in ED, AMU, GP Acute Services

These can be found on the Trust’s Document Library: Document Search

2. The Guidance

2.1. Enteral feeding should be considered if a patient is malnourished / at risk of malnutrition, despite the use of oral interventions and has a functional and accessible gastrointestinal tract (NICE 2006). Formation of a PEG involves the creation of a tract between the stomach and the surface of the abdomen in endoscopy usually under conscious sedation. It should however be noted that nutritional support is not always appropriate.

2.1.2. This procedure can lead to complications that have the potential to be fatal if not detected early.

2.1.3. Scoping our practice NCEPOD 2004 recommended that the multidisciplinary team should discuss the value of PEG feeding for a patient prior to PEG insertion. Patients who are being considered for a PEG should be referred by the medical team for an assessment by the:

- Speech & language therapist
- Dietitian for nutritional assessment and requirements
- Nutrition nurse and/or Gastroenterologist
• Learning disabilities team (if applicable).

2.1.4. The decision to use a PEG feeding tube requires an in-depth assessment of the potential benefit to the individual, requires consideration of physical, psychological, sociological and ethical factors. All patients attending endoscopy for PEG as inpatient or outpatient should have been referred and thoroughly assessed in advance.

2.2. Main indications for PEG placement:

• Dysphagia/ unsafe swallow – assessed by the speech and language therapist
• Increased nutritional needs that cannot be met by eating and drinking alone.
• Long term feeding where patient is not tolerating NG feeding tube or NG no longer safe/ appropriate
• Head & Neck Surgery (RIG preferred technique)
• Neurological acute ischaemic or haemorrhagic stroke
• Chronic progressive neuromuscular disease i.e. Motor neurone disease (bulbar and Pseudobulbar palsies), Multiple Sclerosis, Parkinson’s, Guillain-Barre Syndrome, Huntington’s disease
• Cystic Fibrosis.

2.2.1. Patients with a poor quality of life/advanced dementia are unlikely to benefit from PEG placement.

2.2.2. When selecting patients for PEG insertion the following criteria should be considered: (see 2.12. Contraindications)

• Risk of significant malnutrition and/or delayed recovery
• Upper gastro-intestinal tract dysfunction
• Functional status of gastro-intestinal tract
• Whether enteral tube feeding is likely to be needed for more than 4 weeks
• Acceptability of the PEG to the patient
• Assessment of the patient’s long term prognosis/ medical management plan.

2.3. Referral process:

2.3.1. Inpatients Referrals:
All PEG referrals must be made on the Trust’s MAXIMs. The nutrition nurse and/or Gastroenterologist will assess the patient once the referral form is completed.
Once the assessment has been completed Endoscopy booking will process the referral and arrange a date for PEG placement at the earliest convenience.

2.3.2. Outpatients Referrals:
See flowchart in Appendix 3 Pathway for outpatient gastrostomy referral and assessment.

Patients and or carers will be trained at home on the feeding equipment pre-insertion and will have feeding equipment and feed (if required) ordered by the Home Enteral Feeding (HEF) Dietitian.
2.3.3. Patients will have been assessed in outpatient clinic and prepared for procedure in advance of the day. They should be admitted and clerked on Medical Day Unit and bed arranged if patient planned overnight stay.

2.3.4. Ideal and suggested wards for on-going management: Tintagel, Carnkie and Phoenix wards. Nursing staff have appropriate competencies to manage PEG and feeding safely.

2.4 PEG assessment:

- Identify patients who may require PEG to maximize nutrition and/or hydration; improving quality of life and reduce risks and complications associated with malnutrition and dehydration.
- Improve patient experience
- Improve communication between healthcare professionals
- Standardise assessments and reduce associated risks
- Reduce the number of inappropriate PEG placements
- Reduce the waiting time for PEG placements by prioritizing patients i.e. urgency.

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and / or carer.

The responsible health professional should:

- Consider Best Interest meetings when a patient is unable to consent
- The Speech and Language Therapy (SALT) – will offer advice/assessment and recommendations which will enable the Dietitian to assess whether the patient needs full or partial nutritional support
- The Dietitian will carry out a full assessment of the patient’s current nutritional Intake and nutritional requirements and will discuss with the patient the potential use of the PEG tube. A clear regimen, for water only / feed and water will be devised pre-placement.

2.5. Prior to PEG placement

Indications for PEG placement and contraindications will be considered and based on the individual patient’s needs and wishes. Assessment should be undertaken as per the assessment form (see Appendix 5 PEG Assessment form).

2.5.1. The assessor and/or the referring ward or AHP should ensure that carers / family have received adequate education and counselling, informing them of the potential impact on their lifestyle and body image, including risks and benefits. The patient, family / carer should be provided with an information booklet.

2.5.2. Some patients may require a general anaesthetic for the procedure. The ward will be advised to request an assessment pre PEG procedure if this is felt necessary or arranged as an outpatient following assessment with the gastroenterologist. Normally this would be patients with respiratory
compromise, bulbar involvement or extremely anxious and/or distressed patients who may not tolerate procedure with sedation.

2.6. **Pre-procedure checks before PEG placement** (see 3.1. **Ward preparation prior to PEG**) ward and community responsibilities.

If the patient is unwell on day of or prior to procedure, or no longer requires PEG i.e. clinical condition improved/ deteriorated please contact the endoscopy department in advance as the procedure may need to be postponed or cancelled.

2.7 **Post Insertion.**

2.7.1. **Complications post procedure.**

Complications will most likely result in serious illness or death in the immediate period after gastrostomy insertion. Signs of complications may include:

- Pain on feeding
- Prolonged or severe pain post procedure
- External leakage of gastric contents
- Fresh bleeding
- Aspiration pneumonia.

2.7.2. Monitor NEWS as indicated and check PEG site regularly as per care plan CHA3399 (see Appendix.6 Care Plan CHA3399). All staff should be aware of these aforementioned signs / symptoms. If patient complains of severe pain on feeding, fresh bleeding or leakage of gastric contents feed and medication delivery should be stopped immediately and senior medical advice should be obtained urgently or gastroenterologist/ surgeon.

2.7.3. For possible late complications (see 3.2. **Complications**)

Consider:

- Abdominal USS
- CT scan
- Surgical referral
- PEGogram
- Abdominal X-ray.

2.8. **Post-insertion PEG care / feeding**

2.8.1 Setting up and monitoring of the enteral feeding system, flushing the PEG tube, administration of medications down the tube and initial cleansing of the PEG site post insertion must only be carried out by a Registered Nurse as per care plan.

Nothing should be administered via the PEG tube until 4 hours post placement.

Thereafter an Initial bolus of water (50mls) should be administered before commencing feeding regimen to ensure correct and safe position of PEG and reduce risks of associated peritonitis.
2.8.2. On returning to the ward from endoscopy patient should have a PEG nursing care plan attached in the medical notes (see Appendix 6 Care Plan CHA3399).

2.8.3. The nutrition nurse or Gastroenterologist will aim to review the patient within 48 hours post insertion or as soon as possible. If the patient is discharged before this time or is an outpatient / day case they will be reviewed in the community by the District and/or Community gastrostomy nurses. This will be arranged by the nutrition specialist nurse and / or the Dietitian.

2.9. PEG Feeding and/or water regimen:

- Feed and / or water regimen will be prescribed by the Dietitian and reviewed as required
- Ensure patient fed in an upright position or semi-recumbent and up to 1 hour post feed to reduce risk of aspiration
- Record on fluid balance chart
- Record patient’s weight at least weekly
- Monitor bloods regularly. If at risk of re-feeding syndrome monitor bloods daily during first week, (Urea & Electrolytes, Phosphate & Magnesium)
- Monitor blood glucose level in the initial stages of enteral feeding
- Stool chart.

2.10. Discharge

- Inform Dietitian of proposed discharge date as soon as known
- Training on PEG care, medication administration and feeding equipment should be delivered to the patients/carers by the ward nurse. The dietetic assistants are available to provide additional feeding pump training the patient/carer. Use of the feed pump requires competency based training for both the nurse and the end user.
- The ward Dietitian will arrange patient’s nutrition at home with the local home provider. They will arrange home delivery of feed and feeding equipment and arrange follow up pump training for patient/carers.
- The nutrition specialist nurse will update the community Gastrostomy nurses/ District nurses at or when patient is discharged for providing on-going support and will also liaise with NH/ care agency re any training needs.

2.10.1. Prior to discharge ensure that the patient has:

- 14 day supply of feeding pump giving sets (inpatients only unless emergency admission)
- 14 day supply of enteral feed as prescribed (inpatients only unless emergency admission)
- 14 day supply of 60ml female leur lock purple enteral syringes i.e. 14 syringes (inpatient and outpatient)
- Feeding pump and stand will be supplied by the home provider or this may by the Dietetic department
- Enteral feed regimen (supplied by the Dietitian).
- Nutrition nurse/ward will ensure that the GP is aware of patient’s discharge
- 14 day supply of gauze and 0.9% saline nebules for cleaning the PEG site daily
• Patient PEG information leaflet with red flag sticker and advice to attend ED if any complications i.e. bleeding, increased pain, leakage of gastric contents.
• Information card with interventional radiology contact details for fast track admission if PEG falls out or becomes displaced (01872 253962)
• Do not send ward feeding pump home with the patient.

2.10.2. **For outpatients who require an inpatient stay following the procedure:**

Suggested wards for on-going PEG care: Tintagel, Carnkie and Phoenix wards. Nursing staff have appropriate competencies to manage PEG safely.
Outpatient referrals will be admitted and clerked on medical day unit (MDU) and bed arranged if patient planned overnight stay.

• Ensure PEG care plan and dietetic plan is transferred with the patient to the ward, for on-going management.
• Ensure the patient has his/her feeding regime transferred with them in case feeding is required (note some patients may not be starting feed immediately and will just need to flush tube daily with water, this will have been agreed with the HEF Dietitian)
• Inform the acute Dietitian of the patient’s admission if unplanned overnight admission.
• The patient / carers will have already received feeding equipment and tube care training and will have supplies of feed and equipment at home, if they were originally admitted as a day case patient.
• The patient may need to be shown how to flush their PEG tube with water to maintain patency and support may be needed to start feeding if this is required. Patients will be supported in the community by the District Nurses.

2.11. **Troubleshooting**

For late complications i.e. leakage of gastric, infection, excoriation, over granulation, buried bumper contact the Nutrition nurse or Gastroenterologist. Care plans are available on the document library.

2.11.1. If the tube falls out these needs to be replaced as soon as possible as the tract can heal within a few hours. See troubleshooting guidance on the document library. It is important to maintain the tract open with an ENplug or Foley catheter until a new tube usually balloon gastrostomy tube can be replaced in interventional radiology.
2.12. Contraindications

<table>
<thead>
<tr>
<th>Relative contraindications or medical risks however each patient should be assessed individually:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ascites</td>
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<tr>
<td>• Bleeding disorders, anti-coagulation therapy</td>
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<tr>
<td>• Liver disease</td>
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<tr>
<td>• Gastro-oesophageal reflux with risk of aspiration</td>
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<tr>
<td>• Morbid obesity</td>
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<tr>
<td>• Previous upper GI surgery</td>
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<tr>
<td>• Crohn’s disease</td>
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<tr>
<td>• MI in past 6 weeks/stents (antiplatelets)</td>
</tr>
<tr>
<td>• Peritoneal dialysis</td>
</tr>
<tr>
<td>• Respiratory disease/compromise/COPD/pneumonia</td>
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<tr>
<td>• Anatomical considerations i.e. Kyphoscoliosis as stomach maybe intrathoracic</td>
</tr>
<tr>
<td>• Ventriculo-peritoneal shunts (increases risk of shunt infection but this decreases with time between shunt and PEG insertion).</td>
</tr>
<tr>
<td>• Oropharyngeal and/or oesophageal malignancy - Consider RIG</td>
</tr>
</tbody>
</table>

2.12.1. Ward preparation prior to PEG

Prior to PEG the ward should ensure that:

For those patients who have had poor nutritional intake for 5 days or more by day of PEG insertion, blood tests for serum electrolytes to include Potassium, Phosphate and Magnesium should be taken as these need to be checked before PEG feeding can be safely started to reduce any risk of refeeding

(Refer to out of hours emergency enteral feed regimen if Dietitian unavailable)
- Patient is aware of what the procedure entails including the risks and benefits.
- If travelling from community hospital i.e. CRCH, Bodmin transport will need to be arranged by the referring ward.
- Date for procedure confirmed by CNS/Endoscopy booking.
- Consent form to be signed – consent form 4 required if patients deemed to lack mental capacity
- Clopidogrel and/or warfarin must be stopped 5 days pre PEG insertion.
- Hold Dalteparin and/or DOAC / Aspirin 24 hours’ pre procedure or as advised at pre assessment. Refer to RCHT coagulation/antithrombotic policy for further information.
- Other antithrombotic and/or antiplatelet drugs should be stopped as per RCHT policy and medical/cardiology advice sought if deemed not safe to stop these medications.
• Consent form to be signed – consent form 4 required if patients deemed to lack mental capacity
• Patient is Nil by Mouth or Nasogastric feeding tube midnight (for 6 hours) pre procedure for food, 2 hours for clear fluids e.g. water as per RCHT policy
• Oral care is carried out as per RCHT policy or Royal Marsden manual.
• INR screen must be complete 24-48 prior to patient going to Endoscopy Unit must be 1.4 or less. Any abnormalities corrected as required.
• Up to date MRSA screen (within 3/12)
• IV cannula for administration of prophylactic antibiotics and sedation /GA (if required). Prophylactic antibiotic dose given to reduce risk of peristomal infection
• Patient is wearing theatre gown
• Baseline observations (NEWS) have been carried out and documented
• Endoscopy will contact the ward to send for the patient.

2.12.2. Complications

Immediate complications:
• Pneumoperitoneum
• Pain (some pain is natural and normal)
• Ileus
• Infection/ abscess
• Perforation of the oesophagus or stomach (at a site other than the gastrostomy)
• Damage/ perforation to other intra-abdominal organs, such as the liver or colon
• Haemorrhage
• Peristomal wound leakage.
• Aspiration pneumonia

Late complications:
Occur after the gastrostomy tract has matured (>1 month) they include:
• Deterioration of the gastrostomy site
• Abscess
• Buried bumper syndrome
• Colocutaneous fistula formation
• Leakage of gastric contents
• Necrotizing fasciitis
• Peristomal infection/ abscess (higher in Diabetes mellitus).
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>PEG referrals and outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Nutrition steering group</td>
</tr>
</tbody>
</table>
| Tool                    | Retrospective case note review  
                          | Audit  
                          | Annual report  
                          | DATIX |
| Frequency               | Annually and as arise |
| Reporting arrangements  | Incidents that are uploaded to the NRLS are included in the risk and safety/ clinical governance reports and presented at committee. All serious incidents are subject to root cause analysis along with recommendations and actions. Nutrition steering group Gastroenterology governance |
| Acting on recommendations and Lead(s) | Nutritional steering group |
| Change in practice and lessons to be shared | Required changes to practice will be identified and actioned within A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders |

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Percutaneous Endoscopic Gastrostomy (PEG) Referral and Placement Clinical Guideline V1.0</th>
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</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>September 2017</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>October 2018</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>October 2021</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Tracy Lee Lead Nutrition Nurse Specialist Jenna Chowney Lead Home Enteral Feeding Dietitian</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252409</td>
</tr>
</tbody>
</table>

### Brief summary of contents

The aim of these guidelines is to standardise care for both inpatient and outpatients who require Percutaneous Endoscopic Gastrostomy (PEG) feeding tube insertion. Includes Referral process, PEG assessment, Immediate post procedure care, Using the PEG tube and ongoing care and management, Discharge

### Suggested Keywords:

- PEG
- gastrostomy
- percutaneous gastrostomy tube
- feeding

<table>
<thead>
<tr>
<th>RCHT</th>
<th>CFT</th>
<th>KCCG</th>
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<tbody>
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<td>✓</td>
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</table>

### Executive Director responsible for Policy:

Director of Nursing, midwifery and allied health professionals

### Date revised:

This document replaces (exact title of previous version):

New Document

### Approval route (names of committees)/consultation:

- Nutrition steering group
- Gastroenterology governance

### Divisional Manager confirming approval processes

Roz Davies

### Name and Post Title of additional signatories

### Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings

(Original Copy Signed)

Name: Giorgio Gentile

### Signature of Executive Director giving approval

(Original Copy Signed)

### Publication Location (refer to Policy on Policies – Approvals and Ratification):

- Internet & Intranet ✓ Intranet Only
Links to key external standards

Care quality commission (2009) provider compliance assessment tool outcome 5 (regulation 14) meeting nutritional needs London CQC


Related Documents:


Training Need Identified? No

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
</table>
| March 2018 | V1.0       | Initial Issue      | Tracy Lee Nutrition CNS
Jenna Chowney Lead Home Enteral Feed Dietitian |

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This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

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Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Percutaneous Endoscopic Gastrostomy (PEG) Referral and Placement Clinical Guideline V1.0</th>
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<tbody>
<tr>
<td>Directorate and service area:</td>
<td>Gastroenterology</td>
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<tr>
<td>Is this a new or existing Policy?</td>
<td>New</td>
</tr>
<tr>
<td>Name of individual completing assessment:</td>
<td>Tracy Lee</td>
</tr>
<tr>
<td>Telephone:</td>
<td>01872 252409</td>
</tr>
</tbody>
</table>

1. **Policy Aim***
   - **Who is the strategy / policy / proposal / service function aimed at?**
   - To provide a consistent standard for patient requiring Percutaneous gastrostomy feeding including referral, assessment, pre and post care and discharge.

2. **Policy Objectives***
   - To prevent adverse consequences.
   - Ensure assessment and prepared for procedure to avoid risks.

3. **Policy – intended Outcomes***
   - To ensure all patients requiring a PEG feeding tube are assessed in a timely and safe manner. To ensure that they receive the appropriate preparation both physical and psychological to avoid unnecessary delays, cancellation and reduce the risk of complications. To ensure that they receive appropriate after care and support in the hospital and into the community.

4. **How will you measure the outcome?**
   - Audit and database

5. **Who is intended to benefit from the policy?**
   - All adult patients requiring PEG

6a **Who did you consult with?**
   - Workforce
   - Patients
   - Local groups
   - External organisations
   - Other
   - Yes

   b. Please identify the groups who have been consulted about this procedure.
   - Gastroenterology governance
   - Dietitians
   - Speech and language therapists

   **Please record specific names of groups**

   What was the outcome of the consultation?
   - Approved at gastroenterology governance MDT ready for ratification

7. **The Impact**

   Please complete the following table.

   Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
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<tr>
<td>Sex (male, female, transgender / gender reassignment)</td>
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<tr>
<td>Race / Ethnic communities /groups</td>
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<tr>
<td>Disability - Learning disability, physical disability, sensory impairment and mental health problems</td>
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<td>Religion / other beliefs</td>
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<td>Marriage and civil partnership</td>
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<td>Pregnancy and maternity</td>
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<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.  
   Yes  No  x

9. If you are not recommending a Full Impact assessment please explain why.

   There is no impact on equality stands.

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracy Lee (T.Lee) Policy developer Clinical nutrition specialist Nurse</td>
<td>28/2/18</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tracy Lee</td>
</tr>
<tr>
<td>2. Jenna Chowney</td>
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<tr>
<td>3. Human Rights, Equality &amp; Inclusion Lead</td>
</tr>
</tbody>
</table>

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed: Tracy Lee

Date 27 February 2018
Appendix 3. Pathway for outpatient gastrostomy referral and assessment

GP / Consultant / *AHP to monitor the following parameters
- Unable to meet oral requirements for food & or fluids daily
- Deteriorating bulbar and impaired swallow issues
- Weight loss
*If SLT / Dietitian are not involved refer as Urgent

CONSIDER GASTROSTOMY FEEDING TUBE for declining parameters
Discussion with pt. / carer re gastrostomy benefits Provide Gastrostomy Leaflet – Making the Decision

Mental Capacity

- Yes
- No

Best interest meeting: outcome

- Yes
- No

Refer to NST clinic for gastro assessment

Contraindications:
See The Guidance 3.

- No
- Yes

Patient choice:
Social & Home considerations

- Yes
- No

Formulate plan for ongoing community support

- Yes
- No

Undecided

Review parameters monthly – 3 monthly
Appendix 4. Nutritional Support Team Review

NST Review
See The Guidance 3.3. for Gastroenterology Pre-gastrostomy assessment template

No

Decision to place PEG/RIG

Yes

Not appropriate at present

Consider need for anaesthetic review
Consider need for respiratory assessment
Refer to Intervention Radiology for RIG OR Endoscopy for PEG using MAXIMS referral form
Organise Pre-operative preparations (See Appendix 5 for assessment form)
Refer to HEF Dietitian for pre-gastrostomy nutritional assessment: Rch-tr.DietitiansCornwallHEF@NHS.net
Endoscopy to Inform HEF Dietitian of date of procedure

MDT to Review parameters
On-going clinical review

Formulate plan for on-going support in community

TUBE PLACEMENT

Daycase:
Endoscopy to discharge with
- Redflag information (CHA3399) PEG care plan
- Post tube care information
- Contact numbers
- Gauze / saline
- 14 syringes

Overnight stay:
- Monitor red flag symptoms (CHA3399) PEG care plan
- Commence feeding regime (if required) / or water flushes
D/C as per daycase

COMMUNITY FOLLOW-UP
District Nurse / Gastrostomy Nurse / HEF Dietetics
Appendix 5. PEG assessment form

PEG Assessor: ................................................. Date of Assessment: ...........................................

Designation ........................................ Signature: ........................................ Ward ..............................................

<table>
<thead>
<tr>
<th>Urea:</th>
<th>Creat:</th>
<th>Mg:</th>
<th>K:</th>
<th>Na:</th>
<th>P0₄</th>
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<tbody>
<tr>
<td>INR:</td>
<td>APTT;</td>
<td>Weight:</td>
<td>BMI:</td>
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<tr>
<td>Platelets</td>
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MRSA screen: CRP Age

Reason For Referral/ medical condition

Past Medical History:

NEWS
Date ................................................. RR .................................................
BP .................................................... O₂ Satn on air: .................
Pulse ............................................. Temp .............................................

Mouth Assessment:
Mouth Opening sufficient for scope: YES ☐ NO ☐

Cardiovascular Disease
Myocardial Infarction/ Acute Coronary Syndrome (<8 weeks) YES ☐ NO ☐
History of Heart Failure YES ☐ NO ☐
Recent Chest Pain/ Angina (< 7 days) YES ☐ NO ☐
Other Problems ______________________________________________

Respiratory Disease
Asthma/ COPD YES ☐ NO ☐
Orthopnoea/ PND/ Sleep Apnoea YES ☐ NO ☐
Previous Aspiration Pneumonia YES ☐ NO ☐
Can patient lie flat 20 minutes YES ☐ NO ☐
FVC less than 50%, reduced spirometry capillary blood gases (if available)
Other Problems ______________________________________________
Consider GA assessment

Gastro-Intestinal/ Liver Disease
Recent Dysphagia YES ☐ NO ☐
Previous Oesophageal Stricture YES ☐ NO ☐
Previous Oesophageal Pouch YES ☐ NO ☐
Chronic Liver Disease YES ☐ NO ☐
Known or Suspected Portal Hypertension YES ☐ NO ☐
Abdominal Ascites YES ☐ NO ☐
Previous Abdominal Surgery YES ☐ NO ☐
If YES: site of scar/ incisional hernia: __________________________

Percutaneous Endoscopic Gastrostomy (PEG) Referral and Placement Clinical Guideline V1.0
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### Other Problems

Endocrine Disease

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Mellitus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, treatment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet only</td>
<td>Tablet</td>
<td>Insulin</td>
</tr>
<tr>
<td>‘Sliding Scale’ Insulin required? (d/w ward medical staff)</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

Haematological

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-coagulant/ anti-platelet drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INR/Prothrombin Time Ratio (must be current within 24-48 hours of procedure)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If patient on an oral anticoagulant other than Warfarin, please discuss with medical staff at least 5 days before planned procedure.

Neurological

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Confusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VP shunt</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Social Circumstances

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient able to self-care for PEG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family/ carers able to care for PEG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Nurse support required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Home Support required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implications with aftercare and discharge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other:

Consent

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is patient deemed to have mental capacity as per RCHT guidance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no, has best interest meeting arranged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is PEG decided in patient’s BI</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Multidisciplinary Assessments

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessed by Dietician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessed by Speech and Language Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastroenterologist Assessment required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaesthetic Assessment required</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Discussed at Nutrition MDT</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>If yes, Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Outcome of PEG Assessment

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is patient Suitable for PEG placement?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, planned date of procedure:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no, alternative management plan:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6. Care Plan CHA3399

<table>
<thead>
<tr>
<th>CARE PLAN</th>
<th>CARE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem</strong></td>
<td>Care Plan commencement date</td>
</tr>
<tr>
<td>Care post insertion of a gastrostomy feeding tube 72 hours and checklist for 2 weeks.</td>
<td></td>
</tr>
</tbody>
</table>

**Goals**
- To prevent and monitor any complications post insertion of a new Gastrostomy tube
- To monitor and prevent Gastrostomy related complications and meet nutritional and fluid requirements.

**Interventions**

**Gastrostomy tube details:**
- **Date:**
- **Time:**
- **Type of device:**
- **External fixation device at:** cm
- **Date/ Time patient transferred to ward from endoscopy:**

**COMPLICATION ALERT**

STOP feed/ medication delivery immediately if there is:
- Pain on feeding/ medication, or prolonged or severe pain post procedure, fresh bleeding and/or external leakage of gastric contents
- Obtain senior or medical advice urgently. Do not leave messages on answer phone seek attention immediately.

**Complications include:**
- Chemical Peritonitis, Infection, Bowel perforation, Haemorrhage, Aspiration pneumonia

**Care Instructions:**
- Check endoscopy procedure sheet for any additional/ individual patient instructions.
- Check stoma site: Bleeding, leakages of gastric contents, tube displacement, ensure external fixation device remains in 2-3mm from the skin. If you have any concerns or this appears too tight or loose please refer to endoscopy.
- Nil by Gastrostomy tube /mouth for 4 hours following procedure. Record in nursing evaluation sheet
- Do Not loosen external fixation plate of Gastrostomy tube this may lead to peritonitis and should only be attempted by the clinician/ endoscopy
- Do Not Rotate gastrostomy tube within the first 10 days post insertion

**Immediately post procedure: Complete checklist:**
- Observations: $1/4$ hourly Blood Pressure, TPR and oxygen saturations for 2 hours then $4-6$ hourly or as per NEWS. Record in checklist overlay.