PURPOSE:
To provide hydration, nutrition and medication via surgical opening into the stomach.

CONSIDERATIONS:
1. Gastrostomy feeding may be indicated when passage of a tube through the mouth, pharynx, esophagus and cardiac sphincter of the stomach is contraindicated or impossible. Also used to avoid the constant irritation of a gastric tube in children who require tube feeding over an extended period of time.
2. Placement of a gastrostomy tube may be performed under general anesthesia or percutaneously using an endoscope under local anesthesia.
3. Gastrostomy tubes may be a Foley, wing-tip, or mushroom catheter. Gastrostomy "buttons" are also common in pediatrics.
4. The gastrostomy tube should be taped to the abdomen unless a button or skin level device is in place.
5. Verify placement of tube prior to start of feeding. Check the tube for correct placement. Insert a Secure-Lok extension set into the feeding port and:
   a. Listen for air.
   b. Aspirate residual stomach contents.
6. Check for wetness around the stoma. If there is leakage of stomach contents, check the tube position. Then, as needed, add sterile water, distilled water or saline to the balloon in 1-2 mL increments.
7. Never fill the balloon with more than 10 mL of fluid.
8. During continuous feedings, assess the patient frequently for gastric or abdominal distention. The larger tube that is placed surgically allows for better stomach decompression. For feedings lasting more than 1 hour for older children, or for any child who is medically fragile, the use of an external feeding pump will be more accurate than gravity feedings.
9. Medications may be administered through the feeding tube. Liquid preparations are preferred. Enteric coated tablets cannot be used. Flush tubing to ensure full instillation of complete dose of medication.
10. If a gastrostomy tube is pulled out, cover site with gauze. Reinsert new gastrostomy tube (check tube placement with 1 mL bolus of air: Be sure to aspirate air once placement is confirmed) or instruct caregiver to take child to medical facility (physician order should indicate plan).

EQUIPMENT:
5-60 mL syringe
Graduated container
Glass of water
Prepared formula

Protective sheet
Enteral feeding pump (optional)
Enteral feeding bag and tubing (optional)
Gloves

PROCEDURE:
1. Adhere to Standard Precautions.
2. Identify the patient and explain procedure to caregiver and patient, in age appropriate manner.
3. Prepare measured amount of formula or medication in appropriate container (syringe, graduated container or feeding bag).
4. Elevate the patient's bed to a high- or semi-Fowler's position to prevent aspiration and to facilitate digestion. Infants should be held as during a regular feeding, when possible.
5. Place protective sheet under tubing to protect bedding and clothes. Insert pacifier into infant's mouth to allow for non-nutritive sucking if patient is able to suck.
6. Remove clamp or plug from the feeding tube.
7. Connect enteral bag tubing, pump tubing, or syringe to gastrostomy tube/button.
8. If using a bulb or catheter-tip syringe, remove the bulb or plunger and attach the syringe to the feeding tube to prevent excess air from entering. Elevate syringe so that the tip of the syringe is no higher than infant/child's clavicle.
9. If using a feeding bag, purge the tubing of air and attach it to the feeding tube. Adjust flow rate per physician's order.
10. When using syringe, fill syringe with formula and release the feeding tube to allow formula to flow through. When syringe is three-quarters empty, add more solution. Feed slowly over 20 to 45 minutes.
11. Instill 5-10 mL of warm water before last of nutrient/medication runs in to rinse tubing. For infant, volume needs to be limited, instill only amount needed to flush tubing.
12. Pinch tubing and remove enteral bag, controller tubing and syringe and clamp or cap feeding tube.
13. If a pump is utilized for continuous or periodic infusion, number of mL per hour should be ordered by physician.
14. Leave patient in semi-Fowler's position for at least 30 minutes. Place the infant on his/her abdomen or right side with the head of the crib slightly elevated.
15. If infant/child has excessive air in abdomen, burp after feeding or leave gastrostomy tube elevated and vented for 20 to 30 minutes.
16. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Instruct caregiver to hold and provide stimulation to infant as condition permits.
2. Cleanse all reusable equipment, rinse well. Allow equipment to air dry and wrap in clean towel to be used at next feeding.
3. Document in patient's record:
   a. Amount, color and consistency of aspirated content.
   b. Feeding solution and amount.
   c. Medications administered.
   d. Patient's response to procedure.
   e. Instructions given to caregiver.
   f. Gastrostomy Tube (GT) site assessment.

REFERENCES: