University Hospitals of Derby and Burton NHS Foundation Trust

Management of Jejunal feeding tubes -full clinical guideline (adults)

Reference No:CG-CLIN 4448/24

Purpose and outcomes

This guideline outlines the process for referral, and management of patients receiving nutrition via a jejunal feeding tube within UHDB, it applies to all clinical staff involved in the management of patients who have or require artificial nutrition via a jejunal tube, including PEG with jejunal extension (PEG-J), nasojejunal (NJ) tube, surgical jejunostomy and transgastric balloon jejunostomy.

Post pyloric feeding

If gastric feeding cannot be tolerated or where patients have had major surgery on the upper gastrointestinal tract, post pyloric feeding may be required. This feeding route bypasses the stomach, overcoming problems of gastric feeding.

Jejunal feeding tubes used within UHDB

Nasojejunal tube

Fine bore feeding tube. Inserted via the nose, the tip sits within the small bowel. Inserted endoscopically or radiologically. The cm markings at the nose should be recorded following endoscopic or radiological insertion.
To arrange insertion, refer to the appropriate department.

Percutaneous Endoscopic Gastrostomy with jejunal extension (PEG-J)

This is a long fine bore tube that is inserted through an existing or newly inserted PEG. The tube tip is positioned into the jejunum.
If the PEG is newly inserted, refer to gastrostomy guideline for post insertion care.
The PEG should be inserted approximately 4cm 7 days post insertion, and weekly thereafter but must not be rotated as this will displace the jejunal extension. At RDH this will be performed by the nutrition nurses, by the ward nurses at QHB.
To arrange insertion of PEG and jejunal extension refer to endoscopy. If a PEG is already in place the extension may be inserted radiologically, refer to interventional radiology.

Trans gastric balloon Jejunostomy

Inserted radiologically via the stomach, the tip sits within the jejunal lumen. The tube is held in position with a water filled balloon in the stomach and an external fixation disc.
The water in the balloon must be changed every 2 weeks, this will be performed by nutrition nurses at RDH, ward staff at QHB.
To arrange insertion, refer to interventional radiology.

Surgical jejunostomy

A jejunostomy creates a tract between the jejunum and the abdominal surface. These tubes are usually inserted at the time of surgery directly into the jejunum and are used for early postoperative feeding.
Commence feeding as per surgeon's instructions.
Clean the stoma site daily using an ANTT technique and sterile 0.9% sodium chloride solution and dry thoroughly.
Sutures should be left in place and the site checked regularly for any redness or inflammation.
If sutures become dislodged, they must be replaced, or the tube may migrate from the tract.

General care of jejunal tubes
Jejunal feeding tubes must be flushed with newly opened sterile water whenever the feed is interrupted. If the tube is not in use, it must be flushed at least every 8 hours.
Newly opened sterile water should be used via a 60ml Enfit syringe.
The plunger may be needed to flush fine bore tubes, this must be done gently and slowly.
Continuous feeding may be recommended when feeding via the post pyloric route, there is no gastric reservoir so large volumes of feed may not be tolerated.
Hand hygiene, and no touch technique are crucial as the tube is in the bowel and does not pass through the acid barrier of the stomach.
The insertion site should be cleaned and observed daily for signs of infection or leakage.
For NJ tubes nasal mucosa must be observed daily for signs of pressure damage.
The cm marking at the nose must be checked each time an NJ tube is used.

Mouth care
If the patient is NBM it is essential that regular mouth care is performed to maintain oral health.

Complications
For management of feed related complications, refer to the management of patients receiving enteral feeding guideline.

Nausea or vomitting
This may indicate that the tip of the tube has migrated back into the stomach, the tube position should be confirmed with x-ray.

Pain or discomfort at the stoma site - PEG-J, surgical jejunostomy or transgastric balloon jejunostomy
If insertion site has signs of redness or inflammation, take a swab and treat appropriately if required.
If there is concern that the tube has become displaced a tubogram should be requested.

Tube blockage
To prevent blockage occurring it is important to flush **ALL** tubes 8 hourly, regardless of whether they are used or not.
If however, the tube becomes blocked the following measures can be taken:
Using a 60ml syringe, apply gentle pressure using the plunger, to flush the tube with 5 to10ml of sterile water.
Squeeze up and down the length of the tube, between your fingers and thumb and then try to flush with sterile water again.
Using a 60ml syringe with the plunger, draw 20ml of sterile water into the syringe attach to the tube and use a push and pull technique.

Stoma site infections
If redness, swelling or a discharge is noticed send a swab for M C& S and treat as appropriate.
Ensure that site is cleaned at least once a day and allowed to air dry.
Unless the site is discharging do not apply dressings.
Ensure appropriate topical agents are prescribed and treatment given as prescribed.

Displaced or damaged tube
The parent team need to refer to the appropriate department for replacement tube.

Medication administration

Drugs are not usually licensed for administration via enteral feeding tubes; this has implications for those prescribing, supplying, and administering the drug, as they become liable for any adverse event a patient may experience.

All medications must be prescribed for administration via a jejunal tube and must be suitable for post pyloric administation. For further information refer to the management of patients receiving feed and medication via an enteral feeding tube.

Management of patients receiving feed and medication via an enteral feeding tube guideline

Documentation control

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