CARE MANAGEMENT PROTOCOL

FEED ME PROTOCOL- ADULT: MANAGEMENT OF A PATIENT ON

PURPOSE: To outline the management of patients receiving enteral feeding to maximize enteral therapy and improve the outcomes of patients by using the "Feed Early Enteral Diet for Maximum Effect (FEED ME) guidelines.

WHO MAY PERFORM: RNs

SUPPORTIVE DATA

FEED ME aims to make up for the "lost time" that enteral tube feedings (ETF) are held. Examples of "lost time" include holding ETF for

- Small procedures (line placement, bronchoscopy, etc.)
- Trips to CT Scan, MRI, Interventional Radiology
- Operating Room surgery

Candidate:

- Only patients on ETF who have reached their ordered goal rate

The FEED ME guideline uses a 24 hour period and resets at 12 Midnight (2400) daily.

CONTENT:

PRIOR TO RESTARTING ETF

1. Ensure that a provider order is written to be on the *FEED ME* protocol.
2. Validate that the patient achieved the ordered target goal rate.

INITIAL ASSESSMENT

3. Perform an initial abdominal/GI assessment before restarting the ETF with the new *FEED ME* rate.
4. Assess the following parameters:
   - Bowel sounds
   - Abdominal distension
   - Abdominal pain or discomfort

RESTARTING THE ETF

5. Calculate the total time ETF has been held.
6. Determine the ordered goal rate.
7. Look at the *FEED ME* Guideline in Appendix A.
   a. Find the goal rate on the left column of the chart.
   b. Follow it across to the number of hours held and find the number where they intersect.
   c. Start the new ETF rate and continue until 7:00 am.
8. At 7:00 am, return to the original goal rate (See Appendix B for example).

ONGOING ASSESSMENT

9. Assess the following signs and symptoms of ETF intolerance per routine assessment/reassessment times:
   - Diarrhea
   - Emesis
   - Abdominal distension
   - Abdominal pain or discomfort

SAFETY:

10. Monitor glucose for diabetic patients as ordered.

COLLABORATION:	11.	Collaborate with physicians, Pharmacy Services, and Nutrition Services, as needed.
PATIENT/FAMILY TEACHING:	12.	Instruct on the following: • Identification and reporting of any signs of abdominal intolerance once the FEED ME rate is started • Notification of nurse for immediate problem
REPORTABLE CONDITIONS:	13.	Notify physician for the following: • Signs and symptoms of ETF intolerance
EMERGENCY INTERVENTIONS	14.	In the event of ETF intolerance, perform the following: a. Hold the ETF feeding and notify the physician b. Check for naso/orogastric residual volume (GRV) IF ordered c. If GRV is greater than 500 ml., follow Lippincott procedure on handling the residual (see links to procedure below)
	15.	Check GRV only for naso/orogastric tubes and only when there are signs of ETF intolerance. See #9.
DOCUMENTATION:	16.	Document the following in ORCHID: • The time ETF was held NOTE: Document "0" for every hour that the ETF is off in the intake section of iView • The current rate • The rate change at 7:00 am
	17.	Signs and symptoms of ETF intolerance and interventions undertaken
LEVEL OF EVIDENCE*	Level II B (3), Level IV A (1) , Level V A-B (5)	

Approved by Nancy Blake, PhD., RN, NEA-BC, NHDP-BC, FAAN, and Chief Nursing Officer on June 11, 2019.
Original signature on file.

Protocol and Policy Changes	
Protocol: **PATIENT CONTROLLED ANALGESIA (PCA): MANAGEMENT OF PATIENT ON**	Initial Approval Date: 02/05/209 Revision Dates: 05/19

ASSOCIATED STANDARDS (POLICIES, PROTOCOLS, PROCEDURES, etc.)
Hospital Policy:
Care Protocols: Procedures:

- Lippincott Procedure: **Enteral tube feeding, gastric** **(**https://procedures.lww.com/lnp/view.do?pId=2526634&hits=enteral,feedings,feeding,enterally,feed&a=true&ad=false
- Lippincott Procedure **Enteral tube feeding, gastric** (https://procedures.lww.com/lnp/view.do?pId=2526634&hits=feeding,intolerance,feedings,feed&a=true&ad=false
- Lippincott Procedure: **Enteral tube feeding, continuous, gastrostomy and jejunostomy** **(**https://procedures.lww.com/lnp/view.do?pId=2526636&hits=feeding,enteral,feed,feedings&a=true&ad=false**)**
-

JHNEBP EVIDENCE RATING SCALES*

Evidence Levels	Quality Ratings
Level I Experimental study, randomized controlled trial (RCT) Explanatory mixed method design that includes only a level I quantitative study Systematic review of RCTs, with or without meta- analysis	**Quantitative Studies** **A** **High quality:** Consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence. **B** **Good quality:** Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence. **C** **Low quality or major flaws:** Little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn.
Level II Quasi-experimental study Explanatory mixed method design that includes only a level II quantitative study Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis	**Qualitative Studies** No commonly agreed-on principles exist for judging the quality of qualitative studies. It is a subjective process based on the extent to which study data contribute to synthesis and how much information is known about the researchers' efforts to meet the appraisal criteria. *For meta-synthesis, there is preliminary agreement that quality assessments of individual studies should be made before synthesis to screen out poor-quality studies*[1]. **A/B** **High/Good quality** is used for single studies and meta-syntheses)[2]. The report discusses efforts to enhance or evaluate the quality of the data and the overall inquiry in sufficient detail; and it describes the specific techniques used to enhance the quality of the inquiry. Evidence of some or all of the following is found in the report: ▪ **Transparency:** Describes how information was documented to justify decisions, how data were reviewed by others, and how themes and categories were formulated. ▪ **Diligence:** Reads and rereads data to check interpretations; seeks opportunity to find multiple sources to corroborate evidence. ▪ **Verification:** The process of checking, confirming, and ensuring methodologic coherence. ▪ **Self-reflection and -scrutiny:** Being continuously aware of how a researcher's experiences, background, or prejudices might shape and bias analysis and interpretations. ▪ **Participant-driven inquiry:** Participants shape the scope and breadth of questions; analysis and interpretation give voice to those who participated. ▪ **Insightful interpretation:** Data and knowledge are linked in meaningful ways to relevant literature. **C** **Lower-quality** studies contribute little to the overall review of findings and have few, if any, of the features listed for High/Good quality.
Level III Nonexperimental study Systematic review of a combination of RCTs, quasi-experimental and nonexperimental studies, or nonexperimental studies only, with or without meta-analysis Exploratory, convergent, or multiphasic mixed methods studies Explanatory mixed method design that includes only a level III quantitative study Qualitative study Meta-synthesis	
Level IV Opinion of respected authorities and/or nationally recognized expert committees or consensus panels based on scientific evidence Includes: ▪ Clinical practice guidelines ▪ Consensus panels/position statements	**A** **High quality:** Material officially sponsored by a professional, public, or private organization or a government agency; documentation of a systematic literature search strategy; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions; national expertise clearly evident; developed or revised within the past five years **B** **Good quality:** Material officially sponsored by a professional, public, or private organization or a government agency; reasonably thorough and appropriate systematic literature search strategy; reasonably consistent results, sufficient numbers of well-designed studies; evaluation of strengths and limitations of included studies with fairly definitive conclusions; national expertise clearly evident; developed or revised within the past five years **C** **Low quality or major flaws:** Material not sponsored by an official organization or agency; undefined, poorly defined, or limited literature research strategy; no evaluation of strengths and limitations of included studies, insufficient evidence with inconsistent results, conclusions cannot be drawn; not revised within the past five years
Level V Based on experiential and nonresearch evidence Includes: ▪ Integrative reviews ▪ Literature reviews ▪ Quality improvement, program, or financial evaluation ▪ Case reports ▪ Opinion of nationally recognized expert(s) based on experiential evidence	**Organizational Experience** (quality improvement, program or financial evaluation) **A** **High quality:** Clear aims and objectives; consistent results across multiple settings; formal quality improvement, financial, or program evaluation methods used; definitive conclusions; consistent recommendations with thorough reference to scientific evidence **B** **Good quality:** Clear aims and objectives; consistent results in a single setting; formal quality improvement, financial, or program evaluation methods used; reasonably consistent recommendations with some reference to scientific evidence **C** **Low quality or major flaws:** Unclear or missing aims and objectives; inconsistent results; poorly defined quality improvement, financial, or program evaluation methods; recommendations cannot be made **Integrative Review, Literature Review, Expert Opinion, Case Report, Community Standard, Clinician Experience, Consumer Preference** **A** **High quality:** Expertise is clearly evident; draws definitive conclusions; provides scientific rationale; thought leader(s) in the field **B** **Good quality:** Expertise appears to be credible; draws fairly definitive conclusions; provides logical argument for opinions **C** **Low quality or major flaws:** Expertise is not discernable or is dubious; conclusions cannot be drawn

*Dang, D. & Dearholt, S. (2017). *The Johns Hopkins Nursing Evidence-based Practice: Model and guideline* (3rd Ed.). Indianapolis, IN: Sigma Theta Tau:

APPENDIX A:
FEED ME GUIDELINE
(Feed Early Enteral Diet for Maximum Effect);

Goal Rate ml/hr	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	≥21
100	105	110	115	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120
95	100	105	110	115	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120
90	95	100	105	110	115	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120
85	90	100	100	105	110	115	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120
80	85	95	90	95	100	105	110	120	120	120	120	120	120	120	120	120	120	120	120	120	120
75	80	90	85	90	95	100	105	115	120	120	120	120	120	120	120	120	120	120	120	120	120
70	75	80	80	85	85	95	100	105	115	120	120	120	120	120	120	120	120	120	120	120	120
65	70	75	75	80	80	90	95	100	105	110	120	120	120	120	120	120	120	120	120	120	120
60	65	70	70	70	75	80	85	90	95	105	110	120	120	120	120	120	120	120	120	120	120
55	60	65	65	65	70	75	80	85	90	95	100	110	120	120	120	120	120	120	120	120	120
50	50	60	60	60	65	70	70	75	80	85	90	100	110	120	120	120	120	120	120	120	120
45	50	55	50	55	60	60	65	70	70	80	85	90	100	110	120	120	120	120	120	120	120
40	45	50	50	50	50	55	55	60	65	70	75	80	90	95	105	120	120	120	120	120	120
35	40	40	40	45	45	50	50	55	55	60	65	70	75	85	90	105	120	120	120	120	120
30	30	35	35	35	40	40	45	45	50	50	55	60	65	70	80	90	105	120	120	120	120
25	25	30	30	30	35	35	35	40	40	45	45	50	55	60	65	75	85	100	120	120	120
20	20	20	25	25	25	30	30	30	30	35	35	40	45	50	55	60	70	80	95	120	120
15	15	15	20	20	20	20	20	25	25	25	30	30	35	35	40	45	50	60	70	90	120

APPENDIX B

Example

Case #1:
A patient who is receiving an enteral feeding is scheduled for a procedure at 10:00 am. Currently, the patient is receiving a goal rate of 60 ml/hour.
0900 – Enteral feeding was held in preparation for the procedure. [Take note of the stop time]
1200 – Patient came back to the unit. *There is no contraindication to resume feeding at this time.*

a) Calculate the total hours the patient was off enteral feeding: Answer= 3 hours (from 900 to 1200)
b) Using the FEED ME GUIDELINE, go the first column (Goal rate/hour) and look for 60 ml/hr. Trace the rate perpendicularly and look for 3 (number of hours missed enteral feeding).
c) Based on the FEED ME GUIDELINE, restart the feeding at a rate of 70 ml/hour
d) Continue 70 ml/hour until 0600 the next day.

0600 (the next day) – Go back to the goal rate of 60 ml/hour