

Naso-Gastric Tube feeding under restraint

Best Practice Guidelines for Dietitians

A joint statement from the British Dietetic Association and the Irish Nutrition & Dietetic Institute

Nasogastric Tube (NGT) feeding against a patient's will is an intervention that clinicians working in specialist mental health in-patient units may have to endorse from time to time as a lifesaving treatment. Any use of restraint, including NGT feeding under restraint, should always be a measure of last resort when best efforts to support oral nutrition fail with subsequent deterioration in physical health. There are reports, however, from adult medical wards where the opportunity to do this has not been considered or agreed and may have contributed to a patient's death (Parliamentary and Health Service Ombudsman, 2017).

Many patients with eating disorders are reluctant to eat enough to regain weight or prevent further loss of weight and may need a level of compulsion to help them do this. In most cases, being legally detained is sufficient to compel a patient to feed themselves orally, with appropriate levels of support and supervision. Others may require NGT feeding, but allow this, and either do not resist or only object verbally when it is done. Restraint can vary in degrees, but for the purposes of this document, we will assume the type of restraint that is required when a patient is strongly and physically resisting NGT feeding. This restraint will typically require between 2-5 members of staff trained in safe methods of restraint and safe delivery of NGT feeding. It is not advisable to deliver NGT feeding under restraint without sufficient numbers of trained staff.

The decision to NGT feed a patient under restraint would never be a stand-alone Dietetic decision.

Rather, it should always be a consultant led, multi professional decision in consultation with the patient and their family. Therefore, clear documentation around the decision-making process with a full physical health and mental health risk assessment (including the risks of failing to deliver adequate nutrition) is essential. Consider seeking legal clarification as part of this decision if there is a disagreement.

In order to establish consistency and best practice within the legal frameworks these Dietetic guidelines have been developed. To our knowledge, this is the first Dietetic guidance regarding best practice around NGT feeding under restraint and these are based on the common practices across the numerous dietitians involved in the writing of this consensus document. It is hoped that this guidance will assist colleagues for whom this intervention may be out of the scope of their day to day practice. This guidance will be relevant to Dietitians working in a number of areas; adult medical wards, paediatric wards as well as general /specialist mental health facilities.

Each country across the United Kingdom and Ireland have their own mental health laws governing when a patient is detained for treatment against their will. However, there are overarching principles across the nations in regards to prioritising the least restrictive treatment option, providing treatments that are in the patient's best interest and those that maximise independence. In line with these principles, Dietetic practice has evolved within specialist in-patient settings and the following are best practice guidance for when NGT feeding is required and a patient is resisting or refusing treatment.

Dietitians should ensure that:

Offering of food/oral supplements

- Food and/or oral supplement drinks are offered in a supportive manner prior to considering NGT feeding; never assume based on a patient's previous behaviour that they will refuse to eat or drink. Unless it causes undue distress, it is often useful to continue to offer food/oral supplement at mealtimes in order to give the option to prevent the use of the NG tube.
- At the point of passing NGT the patient should be offered another opportunity to take nutritional supplements / water orally in order to ensure that least restrictive practice is being carried out and that every opportunity to take oral food and fluid has been offered. Note: if a patient has consumed some food/nutrition orally this may have an effect on detecting the correct pH of any aspirates.
- Every patient should have a detailed and individualised dietetic and meal plan in place so that clear expectations have been set - this should state how much the patient needs to eat in order to avoid next bolus feed.

Feed boluses

- Feed boluses to be commenced only when refeeding risk has been assessed and managed - see refeeding section for full guidance.
- Feeds should be delivered via syringe bolus and not gravity bolus or enteral pump to ensure delivery in the most appropriate timeframe. In specialist mental health in-patient services, common practice implies that it is safe to start at 1 x 50ml syringe per minute and increase as tolerated to 2 x 50ml syringes a minute with careful monitoring.
- Bolus feeds can be started at 500ml per bolus, delivered over 5-10minutes (this volume includes any pre and post NGT feed flushes) and this can be increased every day by 100-200ml up to 1,000ml as required. Delivering boluses >1,000ml has been managed safely but it is not viewed as standard practice (Falcowski & Fuller – In press).
- The number of feeds a day is reduced to two (Fuller *et al.*, 2019) in order to reduce episodes of distress and risk to the patient as well as staff. One feed a day could be considered in extreme circumstances when there are no concerns around the patient's physical health i.e. very low weight, low blood sugars or risk of refeeding syndrome etc. However, one feed a day of up to 1,000ml will not meet the patient's fluid requirements so the patient will either need to be encouraged to drink water orally or have a bolus feed just of water – for which there may be significantly less resistance or no resistance at all. If a patient is on one or two feeds a day, monitor the patient's Liver Function Test (LFT) to ensure that this is tolerated.
- When NGT feeding as a short-term intervention, using a high calorie i.e. 2-2.4kcal/ml feed ensures maximum nutrition can be delivered in a small volume. However, this may lead to very high levels of protein and high levels of some micronutrients being delivered and the patient will need their urea levels checked to see if this is being tolerated. If urea levels become raised, during longer term feeding, consider switching to a lower energy and protein feed i.e. 1 – 1.5kcal/ml.
- Oral supplement drinks containing additional fibre may be required to address any issues with constipation if used as a sole source of nutrition.

Fluid

- The MDT can consider adding water e.g. 100-300ml to the feed bolus to reduce the viscosity of feed thus aiding the administration of the feed via syringe.
- Fluid requirements are documented by the dietitian and nursing staff are advised on how to manage this alongside any oral fluids completed.
- The MDT is aware that patients who are refusing fluids are more vulnerable to medical instability and therefore consider a lower threshold for intervention with NGT feeding in these patients

Refeeding Syndrome

- If a patient is at risk of refeeding syndrome the appropriate medical monitoring for refeeding is adopted as well as any prophylactic vitamin / mineral supplementation in line with local policy.
- If a patient is at risk of refeeding syndrome it is important to avoid underfeeding:

- In patients under the age of 18 years starting at 1,200kcal/day has been demonstrated to be safe with appropriate medical monitoring (O'Connor et al., 2016)
- In adult patients starting at 30-35kcal/kg body weight is used in practice (Mathews et al., 2018, Patton & Philpot, 2018).

Tolerance

- A patient's tolerance to syringe bolus feeding regimen is monitored daily and adjusted if a patient has any adverse symptoms related to bolus volume or rate.

Dietitians should not:

- Endorse the delivery of bolus feeds via enteral pumps where the patient is resisting feeding (unless medically indicated) as the delivery rate is too slow and the restraint will become prolonged.
- Support the use of nasal bridals unless there is a specific medical reason to do so.

Other individual care plan considerations within the MDT

- Every Trust / unit should have a clear care plan for management of NGT feeding when physical interventions are required to ensure patient and staff safety and consistency
- Dietitians should encourage the use of existing risk assessment frameworks in order to identify when a patient's life may be at risk (Royal College of Psychiatrists 2012 and 2014) and ensure that teams have their own policies regarding low blood sugar levels and when to treat – always treat if someone is symptomatic of hypoglycaemia and be aware that complex medical conditions e.g. liver failure, may result in someone having a lower threshold of when medical intervention is required.
- Consider medical review if a restraint has lasted longer than 20mins (units should have their own policy regarding if a presence of a doctor is required for the duration of the restraint)
- Consider requesting a medication review to see if any pharmacological adjuncts could be prescribed to reduce resistance and distress
- Dietitians should always be aware of additional psychiatric risks that these patients may have and endorse the removal and subsequent reinsertion of the NGT at each feed if there is a safety risk e.g. ligature or risk that the patient may be self-aspirating the feed via the NGT after the restraint has finished
- Dietitians should not endorse a patient being NGT fed in a supine position, unless there is a medical reason, patients should be restrained in a seated position
- Do not leave NGT's in situ for longer than indicated by manufacturing guidelines due to the risk of the NGT deteriorating and nasal pressure sores.
- Continuously review, the need for NGT feeding under restraint as an MDT

Recommendations for future guidance

There is a need for further multi-professional guidance in regard to NGT feeding under restraint as, clinicians understand that NGT feeding under restraint may be needed in 'lifesaving circumstances'. However, these are not clearly defined – many mental health services are using existing medical monitoring frameworks (Royal College of Psychiatrists 2012 and 2014, Kings College London, 2009) to define when a patient needs to be NGT fed against their will. However, as this intervention can be seen as an aggressive or invasive treatment it must be fully weighed against the patient's quality of life. Regular and full MDT reviews of patient's treatments, including second or external opinions from an eating disorders psychiatrist and the role of the court of protection should be considered in cases of prolonged feeding against a patient's will with little treatment response (Court of protection, 2016). Furthermore, there are no existing guidelines regarding when to stop this treatment if a patient's life is no longer at risk nor under what circumstances outside of 'lifesaving' could NGT feeding against a patient's will be appropriate. Nor is their guidance around the ethical considerations that this intervention brings.

There is not yet guidance around other aspects of NGT feeding under restraint such as: medication strategies, nursing care planning, ethical considerations and the therapeutic impact this intervention may have. Further guidance would ensure that this intervention is practiced safely, consistently and within the framework of the law.

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Patient and carer representation feedback:

Roseanne Jones – expert by experience

I never considered how difficult it would be to assess whether a patient needs NG feeding under restraint, or how to judge whether their life was at risk if no feeding takes place. NG feeding is sometimes the nudge that can kickstart recovery. Reading the guidelines made me realise just how lucky I was to be in a hospital with such skilled staff.

Kim Daniels – carer

How sad to think that lives are being lost because guidelines like this do not exist. It brings back horrible memories for me, when Rosy was being fed under restraint, but I know it saved and changed her life - it gave her no choice, when she could not to eat at all.

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