Blended Feeding Policy
Administration of Liquidised diet via Gastrostomy Button In the Community Setting.

Document Author	Authorised
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Lead Medical Director: Dr Sian Butterworth **Director of Nursing:** Barbara Stuttle	
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DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
August 2017	0.1		Dr Sian Butterworth	New Policy	
23/03/18	0.1		As above	For ratification	Clinical Standards Group
		23rd February 2018	As Above	For Approval	Policy Management Sub-Committee

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

Contents

1 Executive Summary

This policy applies to all children and young people, 0-19yrs, who have liquidised food admistered via a gastrostomy button. These children will have access to a children's community nurse and be under the care of a paediatric dietitian. Healthcare, Education and Social Care professionals, parents and other care givers will need to be aware of this policy.

2 Introduction

The number of children and young people with complex care needs or life limiting conditions is growing which has led to an inevitable increase in enteral feeding (children being fed via a feeding tube most commonly a Nasogastric or Gastrostomy tube). Children can have difficulty in swallowing, digestive issues or neurological/muscular disorders. Gastrostomy feeding accounts for about a third of all children receiving artificial nutrition nationally.

The gold standard for gastrostomy feeding is to use prescribed tube feeds defined as Foods for Special Medical Purposes to provide the child with a complete source of nutrition which meets their nutritional requirements. This can be monitored and reviewed at regular intervals ensuring that the child is receiving a complete diet for their age. This can then be adjusted as need dictates with the ability to alter tube feeds should one not be tolerated as well or to meet the young person's changing needs. Tube feeds are designed to be administered via enteral feeding tubes and therefore rarely cause tube blockage, they are easy to prepare, administer and they are sterile thus reducing the risk of infection.

There is currently an increase in interest in the use of liquidised food (blended feeding) as an alternative to tube feeds, particularly for children. Understandably, parents wish for their child to have the same choices as a child who is orally fed. There are increasing amounts of powerful messages being advocated via social media which are geared towards natural foods and the health benefits of eating a varied diet including fruit and vegetables. There are also many anecdotal reports from parents, carers and health professionals detailing the benefits, including improvement of food intake of those with chronic diarrhoea and those after fundoplication surgery. Better tolerance and reduction in vomiting has also been reported. (Coad et al 2016). There is emerging evidence that a liquidised diet has a wider social benefit improving the relationship between child and parent and allowing families to be more involved with tube feeding. However, there is little evidence based research regarding the benefits of blended feeding and it remains a procedure that is unapproved for many trusts and not recommended by the British Dietetic Association, Enteral Plastic Safety Group or present NICE guidance.

Children who are tube fed receive input from a variety of healthcare and non-healthcare professionals and there is a need for all involved to support parents/patients in adopting safe practice, as long as this is an informed choice about how best to provide complete nutrition whilst maintaining safe practice.

3 Definitions

Gastrostomy – A surgical opening into the stomach.

Jejunostomy – is the surgical creation of an opening (stoma) through the skin at the front of the abdomen and the wall of the jejunum (part of the small intestine). It can be performed either endoscopically, or with formal surgery.

Enteral Feeding – refers to any method of feeding that uses the gastrointestinal (GI) tract to deliver part or all of a person's caloric requirements. It can include a normal oral diet, the use of liquid supplements or delivery of part or all of the daily requirements by use of a tube (tube feeding).

Bolus Feeding – is a type of feeding method using a syringe to deliver formula through your feeding tube. It may also be called syringe or gravity feeding because holding up the syringe allows formula to flow down using gravity.

Pump Feeding - is given continuously over a long period of time, usually 8-24 hours.

Fundoplication - a surgical procedure in which the upper portion of the stomach is wrapped around the lower end of the oesophagus and sutured in place as a treatment for the reflux of stomach contents into the oesophagus.

4 Scope

The Enteral Plastic Safety Group (EPSG), which represents all device manufacturers in the UK, has reached a consensus not to endorse this method of enteral feeding practice Manufacturers do not recommend the use of blended feeding via a percutaneous endoscopically placed gastrostomy (PEG) because of the risk of tube blockage and unknown damage that could occur with the tube. This policy is therefore only for patients who have gastrostomy button devices. Currently, only the manufacturers of Mic-Key (Vygon) and Mini (GBUK)- state in their literature that their tubes are suitable for the use of homemade liquidised food. The use of other devices, for example, nasogastric and jejunostomy tubes, fall outside this policy.

This document is relevant for all parents, patients, carers, health and social care professionals who are involved in administering and/or supporting a blended diet.

5 Purpose

This document aims to provide parents, healthcare, education and social care providers with guidance and recommendations in how to support parents and carers in administering and maintaining a blended diet for their child/children. It is hoped that by providing information in a structured and evidence based way, families will be able to make an informed choice thus reducing risk and increasing positive patient outcomes.

This document has been written in response to parental request and due to a generalised increase in interest in feeding children with a blended diet in the local area.

6 Roles and Responsibilities

Children's Community Nurses – to train parents/caregivers/professionals involved in the care of the identified patient and to offer annual updates on training requirements.To be an advisory on the care of the button device. To arrange clinical assessments for the monitioring of nutritional status and height and weight.

Dietitian – To monitor the nutritional intake of the patient and adjust and advise as necessary on dietary requirements, the frequency of blood testing, weight and height measurements. To ensure full risk assessment has been undertaken and agreed upon.

Caregivers/Parents – To administer liquidised diet as advised by the dietitian and sign the risk assessment form. To ensure the child is brought for clinical monitoring as required by the dietitian.

7 Policy detail/Course of Action

The IOW NHS Trust has a legal responsibility for Trust Policies and for ensuring they are carried out effectively. The document will need to be approved at committee and Heads of Services will need to ensure that all relevant staff are aware of the content and adhere to the principles and guidelines. Staff involved in advising on the use of blended diet via a gastrostomy button and all the processes within that will need to work in accordance with the procedural guidelines contained within this document.

Methods of Administration

Gastrostomy

There are several different types of gastrostomy devices in the UK. The type needs to be considered before commencing liquidised feeding. Manufacturers do not recommend the use of blended feeding via a PEG device because of the risk of tube blockage. This policy is therefore only for patients who have Gastrostomy buttons. Currently, only the manufacturers of Mic-Key (Vygon) and Mini (GBUK) state in their literature that their tubes are suitable for the use of homemade blended food.

Jejunostomy Tubes

It is not recommended to use a jejunostomy for liquidised feeds. There is no evidence to support this method and there are concerns regarding nutritional absorption, as feeding into the jejunum bypasses the digestive mechanisms increasing chances of infection. The jejunum is also not meant to store volumes of food so overloading can be a potential risk. The tube itself is also narrow causing a high risk of blocking.

Size of tube

The risk of blockage increases as the gauge decreases. The minimum tube size recommended is 14FR. (Mortenson 2006, Novak, 2009, Pentiuk et al 2012, Johnson 2016)

The following should also be considered prior to commencing liquidised feeds:

- Size of button needs to be changed if smaller than 14fr
- Parent/Carer need to be trained in administration of bolus feeds and has demonstrated competency in managing enteral feeds and stoma care.

- Parent to be trained in replacing gastrostomy buttons to prevent hospital admission and if it is not a replaceable device then a contingency plan needs to be in place for the hospital to follow.
- Frequency of device changes should be monitored by the community team for clinical and cost reasons.
- Types of syringes and extension sets should also be monitored for clinical/cost effectiveness

Pump Feeding

- Enteral feed pumps are designed to be used with commercial food formulations not liquidised food. No pump manufacturer supports the administration of liquidised food via a pump. Pump feeding of liquidised foods is not recommended due to the risk of microbial contamination with prolonged hanging times and the potential nutritional inadequacy of more dilute blends.

Dietitians Role

When an individual, or their carer, is considering the use of liquidised food the Dietitian:

- Has a duty of care to ensure the patient/carer has had all the individualised information they need to enable them to make a fully informed choice
- The information must include making the patient/carer aware of the potential risks to health and the viability of their feeding tube

The Dietitian will ensure that the clinical team caring for the patient:

- Considers all alternative feeds and feeding strategies
- Discusses, and fully documents, the reasons for the patient/ parent/ carer decision
- Have endorsed the practice

The Dietitian alongside the consultant and community nursing team will carry out a full risk assessment to highlight and ameliorate the potential health risks that are specific to the individual patient. Consideration must be given to the environment in which the liquidised food will be prepared and to the mode of delivery.

Childrens Community Nurse Role

A home visit by the Community Nursing Team should be undertaken to assess the preparation area to ensure the environment is suitable for blended feeding and make recommendations as per BDA guidelines for reducing contamination.

To teach patient /carers on how to manage the care of the button device.

Risk Assessment

The reasons stated why the patient/carer wish to use liquidised food, together with the outcome of the Multi Disciplinary Team (MDT) or Best Interests Meeting, will be documented in the medical, dietetic and any other health records.

The MDT must decide if the chosen feeding method *represents an unacceptable risk* and is likely to lead to significant harm. If this option is still pursued by the patient / carer then the team must ensure local safeguarding procedures are followed.

The risk assessment (appendix A) will be agreed and signed by the patient / carer, dietitian and consultant and filled in the medical records.

The dietitian will provide an alternative regime in consultation with the patient / carer that will be used if the patient requires inpatient or hospice stay where the liquidised diet cannot be provided. The patient / carer will also agree the liquidised feeding plan with the Dietitian. A copy of the regimens will be stored in the dietetic / medical notes.

The risk assessment should be shared with anyone giving liquidised food and clear protocols should be in place along with trained staff.

Monitoring

Patients receiving a blended diet require closer monitoring due to the impracticality of completing a full dietary analysis of all liquidised food recipes and meals given and the variability of nutritional intake even when analysis is carried out. Research suggests that even if the liquidised food is fully analysed the content cannot be guaranteed, due to the processing, seasonal variation and origin of ingredients.

Pentuik et al (2011) advocate dietary monitoring by experienced dietitians to ensure appropriate intake with nutritional bloods for patients after three months. Bloods will then be repeated at six monthly intervals unless otherwise clinically indicated.

Patients will be weighed monthly and have their height measured every two months.

Any concerns regarding growth and nutritional status will be addressed with the patient /carer and if recommendations are not adhered to then safeguarding procedures will be commenced as per local policy.

The dietitian will devise an individualised monitoring plan with the patient and community nursing team using the suggested good practice guidelines from the BDA approved Practice Toolkit.

Administration

Only staff that have been trained in the use of button devices will be able to advise on the administration of liquidised feed. See appendix (D).

8 Consultation

This document has been sent to Lead Consultant, Infection Control, Dietetic Department and parents who have a child wishing to administer liquidised diet. It is the first policy of its kind within this trust in response to parental need and developments with regard to the benefits of blended feeding.

The introduction of this Policy will mean that parents wishing to undertake the administration of liquidised feed via a gastrostomy are able to do so within the realms of the trust guidelines. It will promote families choices in how they wish to feed their children and will bring the trust into line with other specialist areas where liquidised feeding is already an approved option.

9 Training

All persons involved in using gastrostomy buttons will have undertaken training provided by the relevant healthcare professional. The identified trainee will be assessed and signed off as competent by a trained health care professional. This will then be reviewed annually.

Parents will be provided with advice on preparing, storing and administering liquidised foods. Appendix (c)

This document will be passed through the trusts internal approval committee and cascaded to the relevant healthcare professionals, including ward staff, Doctors and Consultants, Dietitians and Shared Care Hospitals if appropriate.

10 Monitoring Compliance and Effectiveness

This document will be utilised for all patients and/or parents wishing to administer blended feeds. Copies of this policy will be kept in the individual's health records in order for the information to be used for each parent/carer involved in the care. The blended diet will be reviewed and monitored by the Dietitian and the Community Childrens Nursing Team to ensure the child is receiving a varied diet and that they are growing and developing as expected. Any concerns will be raised with the family and reported upon to the relevant healthcare/medical professional.

The amount of patients requesting and/or undertaking blended feeding will be collated by the dietitian and references for healthy growth and development recorded.

11 Links to other Organisational Documents

BDA Policy Statement, Use of Liquidised Food with Enteral Feeding Tubes. 2016

Childrens Act 1989

Coulter A and Collins A. making shared decision making a reality: No decision about me, without me. The Kings Fund 2011

Equity and Excellence: Liberating the NHS. Department of Health White Paper 2010

Parental and Enteral Nutrition Group of the BDA Risk Assessment Template for Enteral Tube Administration of Liquidised Diet. Available from:
http://www.peng.org.uk/publications-resources/resources-for-hcps.php

Recommended reading from Parent:
Complete Tubefeeding by Eric Aadhaar O'Gorman (isbn: 9781470190224
https://www.amazon.co.uk/Complete-Tubefeeding-Everything-tubefeeding-nutrition/dp/1470190222 and
Homemade Blended Formula Handbook by Klein and Morris ISBN: 9780692651247
https://www.amazon.co.uk/Homemade-Blended-Formula-Handbook-Marsha/dp/0692651241/ref=sr_1_1?s=books&ie=UTF8&qid=1517929508&sr=1-1&keywords=9780692651247

12 References

Anderton, A. Microbial aspects of home enteral nutrition – a discussion 1990, 1990 Journal of Human Nutrition and Dietetics 3, 403-412

BDA Policy Statement, Use of Liquidised Food with Enteral Feeding Tubes, The Association of UK Dieticians, 2016

Coad et al Blended foods for tube-fed children: a safe and realistic option? A rapid review of the evidence. Volume 102, issue 3 2016

Johnson TW, Spurlock A and Galloway P. Blenderized formula by gastrostomy tube a case presentation and review of the literature. Topics in Clinical Nutrition 2013: 28(1): 84-92

Mortenson M. Blenderized Tube Feeding Clincal Perspective on Homemade Tube Feeding. Pediatric Nutrition Practice Group Post 2006:17(1):1-4

NICE (National Institute for Health and Care Excellence) Clinical Guideline 139 Infection, Prevention and control of healthcare-associated infections in primary and community care (2012)

Novak P, Wilson KE, Ausderau K, Cullinane D. The use of blenderized tube feedings. Infant Child Adolescent Nutr 2009; 1:21-23.

Patchell CJ, Anderton A, Macdonald A, George RH and Booth IW. Bacterial contamination of enteral feeds. Archives of Diseases in Childhood 1994: 70:327-330

Pentuik SP, O'Flaherty T, Santoro K, et al. Pureed by gastrostomy tube diet improves gagging and retching in children with fundoplication. Journal of Parenteral and Enteral Nutrition. 2011:35:375-379

Thomas S, (2017) Multi-agency practice for developing a blended diet for children fed via a gastrostomy. Nursing Children and Young People 29,6,22-25

White S, Clark S, Torrance A, Bottril P and Matthewson K. Evaluation of a liquidised normal food as an alternative for PEG-fed patients. Journal of Human Nutrition and Dietetics 1999:12:43-46

WRAP Review of the literature about freezing food at home (June 2012). T Brown and J Evans. Available from http://www.wrap.org.uk/

13 Appendices

Appendix A

Appendix B

Appendix C

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Appendix A

Risk assessment for the use of a blended diet via a button gastrostomy

Risk	Details	Recommendations to reduce risk
Nutritional deficiency and decline in nutritional status	Non adherence to enteral feeding care plan Uncertainty regarding nutritional adequacy of the blended diet. Potential for larger feed volume. Blended diet may have a lower Kcal content than commercial products	Blended meal to consist of a source of protein, carbohydrates and vegetables / fruit. It is paramount that parents / carers to provide three days of blended meal recipes for review by dietetics prior to quarterly dietetic review Consider the use of energy dense fluids to dilute the food to the desired consistency. Discuss the option to use a combination of commercial enteral feeds and blended diet. It will be agreed that the following measurements will take place: Weight – Monthly Height – Two monthly Bloods (including electrolytes, vitamins and minerals will be carried out 3 months most initiation and repeated 6 monthly unless clinically advised otherwise. A months food and symptom diary will kept by parents/carers pre and post commencing blended feeding
Tube Health / safety	Devices other than buttons (e.g. gastrostomy tubes) are not approved by the manufacturers for the administration of liquidised feeds. Manufacturers product licence voided, thus eliminating the purchasers rights to refund if faulty Early deterioration of devices or associated equipment could result in feeding tubes needing to be replaced sooner than recommended, which is invasive and impacts on NHS costs	A GBUK Mini button is approved by manufacturer for blended diets. With any other feeding tube it is to be documented in all records that the patient / parents / carers have chosen to use a medical device which is outside the scope of the manufacturer's information for use guidance. Regular checks of the tube by parents / carers who must report and deterioration in the feeding tube. Review and monitor frequency of device change This method of feeding cannot be given into the jejunum. Have parents / carers been trained to replace the device to prevent hospital admission, if not what is the impact on the trust?

Tube blockage	Unsuitable consistency of blended food.	Ensure consistency of blended food is the same as commercial feeds and is smooth. Flush feeding tube with minimum 30ml water after administration Consider tube diameter: Minimum 14FR recommended Have parents / carers been trained to replace the device to prevent hospital admission, if not what is the impact on the trust?
Infection	Risk could arise from: • Inappropriately or undercooked foods • Inappropriate storage of feeds • Poor hand hygiene • Particles of food remaining in the tube after feeds • Poor cleanliness of equipment used	Blended feeding should not be given to those who are immunocompromised Appropriate storage conditions of prepared feeds: Blended food should be prepared as close to administration time as possible. Blended food should not remain at room temperature for longer than 2 hours. Blended food may be stored on the top shelf of the fridge (below 5°C) up to 24 hours. Blended food may be frozen (below-18°C). Food should not be kept for longer than one month. Food safety guidance on defrosting should be followed. Follow the use by date advice given by manufacturers. Promote good hand hygiene Ensure feeding tube is flushed immediately after all feeds Ensure liquidiser/blender and any other equipment is of a design which can easily be cleaned thoroughly Blended food should be stored in appropriate food containers, clearly labelled with what it is and when it was prepared. If you are going out, cool bags (with a cool pack) are ideal to store the containers of blended food to keep them at an appropriate temperature for short periods of time. Consider increased supply of single use syringes and extension sets to reduce the

		risk of contamination but this will have increased costs to the Trust
Feed administration	Blended food is not suitable for pump feeding, as the feeding pumps are not calibrated for blended feeds Blended feeds may not remain in suspension for a prolonged period of time Thicker consistency may make gravity feeding impractical Potential uneven heating or over heating of blended feeds	Bolus feeds via syringe will be required. Avoid warming feeds if possible, if refrigerated remove 20mins before administration to allow to come to room temperature If the feed is warmed ensure it does not exceed hand temperature and that the food is remixed after heating.

Any Specific risks identified: Actions identified to reduce risks:

Dietitian Name…… Role……

Signature……..

Date……

Senior Medical Clinician ……

Signature……..

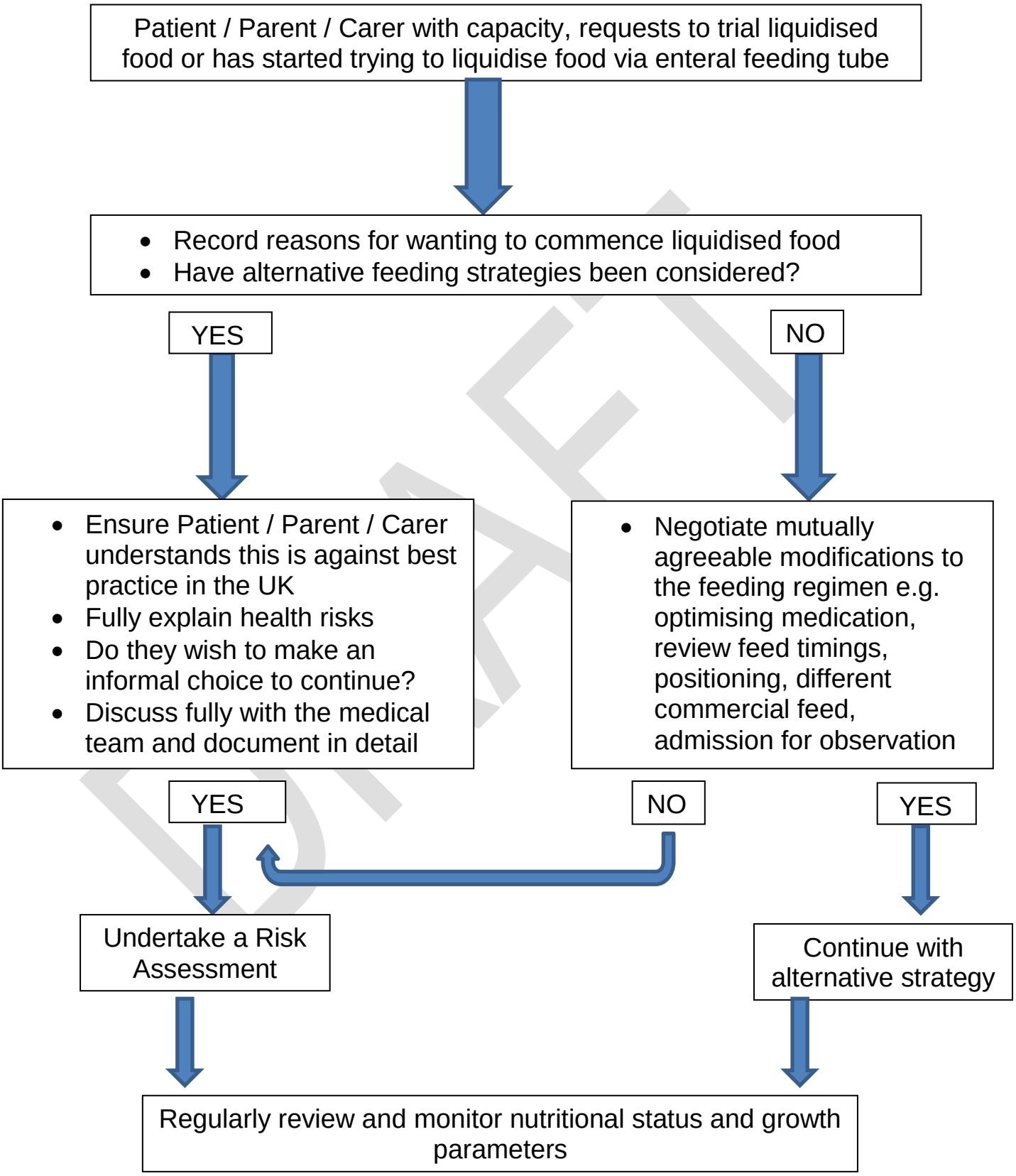
Date……

Patient / Parent / Family / Carer …….

Signature……

Date……..

Appendix B



Appendix C

Preparation and Storage.

Liquidised food can be prepared using a hand blender, basic jug/stick blenders and a sieve. A sieve is very important in order to ensure the food is lump free. A high power blender would be recommended in order to optimise the foods which can be used and to enable a smooth consistency to minimise risk of tube blockage.

Preparation and storage of the liquidised food is fundamental to the microbial safety and nutritional content of the feed. (Anderton 1990) This area of research has prompted the information surrounding the negative aspects of liquidised feeding. (Patchell 1994)

NICE guidance (2012) on preventing and reducing the risks of infection in relation to enteral feeding emphasises the importance of effective hand washing prior to handling enteral feeds. NICE guidance recommends that wherever possible pre-packaged ready to use feeds should be used. Hand washing techniques and decontamination of work surfaces is integral to preventing bacterial contamination.

White (1998) found that liquidised foods should be kept refrigerated and used within 24hrs. WRAP 2012 (Waste and Resources Action Programme) found that the length of time a food is frozen for can affect its nutritional quality. Food should be labelled in a reusable container. Cool bags are ideal to store the containers of liquidised food. Food should be defrosted properly before use.

The following suggested good practice has been taken from the BDA recommendations.

- Food prepared outside the home environment or in a commercial environment needs to meet current Food Hygiene Regulations
- Emphasis needs to be placed on good hand hygiene and washing, food safety and kitchen hygiene techniques
- Effective handwashing must be carried out before starting food preparation and a risk assessment of the food preparation area should be considered – commercial premise manager or home visit for a community patient
- Use of a high powered blender should be considered to minimise risk of tube blockage and maximise nutritional content
- Liquidised food should be prepared as close to administration as possible
- Liquidised food should not remain at room temperature for longer than 2 hours
- Liquidised food may be stored on the top shelf of the fridge (below 5 $^{\circ}$C) for up to 24 hours
- Liquidised food may be frozen (below-18 $^{\circ}$C) ideally for no more than a month. Food safety guidance on defrosting should be followed
- Consideration should be given to the possibility of an increased supply of ancillary equipment which may be required to help reduce the risk of contamination

Administration

- Use a 60ml syringe to draw up the liquidised food. If food is difficult to draw up it may need blending again. Attach syringe to the extension set and connect to gastrostomy button
- Once food consistency has been checked pour the blended feed into the syringe
- If the blended food does not flow through by gravity alone gentle pressure may need to be added
- If required a break and small flush of cooled boiled water may be needed to prevent tube blockage in between syringes

- Continue process until all feed is administered
- Discard any remaining feed
- Never reheat food (Please see Appendix C)

If there is any concern by the individual who is expected to administer the feed ask the parent/carer to provide an emergency supply of easily stored and transportable feed.

Appendix D

Staff Guidance and Risk Management For Administering Blended Food via Gastrostomy

AREA OF CONCERN	MANAGING RISK
BLOCKAGE OF GASTROSTOMY Internal diameters of gastrostomies and PEGs range from 1.9mm to 2.9mm (measurements confirmed with manufacturers) This means we must blend and sieve food to avoid blocking the narrowest parts of the button.	Blend food, using blender, to a smooth consistency All food will then be sieved using a fine metal sieve. Flush well with cooled boiled water in between amounts and after feed has completed.
DAMAGE TO GASTROSTOMY To prevent degradation of gastrostomy and potential rupturing of tube. Plunge feeding is not recommended.	Food will be blended to a "pouring custard like" consistency; if food is too thick to plunge it will need thinning by either adding more fluid and/or blending again. Administer feed slowly, over 20 – 40 minutes. Use ONLY a 60ml syringe Flush gastrostomy with cool boiled water – minimum of 20mls for buttons to clear food from tubing
AREA OF CONCERN	**MANAGING RISK**
LEAKAGE	Observe for signs of persistent leakage from around the gastrostomy site which is not normal for the child/young person Continue with basic gastrostomy care as advised by community team
HYGIENE/INFECTION CONTROL Risk of increased micro-organisms due to build-up of food being left in the tube Blended feeds should be stored in the fridge after defrosting and used within 24hrs. After this time food should be discarded.	Only use food that is clearly labelled with child's name; date of preparation; date of defrosting and/or stored in fridge Hand washing before handling administration sets and when preparing or handling food to be administered. Wash extension sets and syringes in warm soapy water and air dry **IF FOOD IS BEING TRANSPORTED FROM HOME, IT MUST ARRIVE FROZEN.**

	STORAGE OF FOOD Food must be clearly labelled with name/date of preparation/main ingredients (this is for staff handling the food) Place frozen food immediately in the freezer once prepared. Allow to defrost in kitchen fridge and use within 24 hours – label with date/time placed in fridge. Shop brought food such as Ella pouches, jar stage one baby food and yoghurts should be sealed and in date. Store in fridge for no more than 24 hours once opened.

(Adapted from Children's Hospice, South West)

GIVING BLENDED FOOD:

Equipment: on a clean tray, 2X 60ml syringes provided by parents, giving set, water for flushing, paper/kitchen towel and gloves.

Feed: if feed has been previously frozen check it has been properly defrosted. Any concerns from the carer giving the feed that it has spoiled. **DO NOT** give. Consistency of a feed may change after being frozen.

Flush tube with water to ensure it is patent.

Use a 60ml syringe to draw up blended food keeping the tip submerged to avoid air pockets.

Wipe end of the syringe with paper towel before attaching to extension set.

Slowly syringe feed, ideally 5-10mls at a time with a pause mimicking oral feeding, 60mls should ideally be given over at least 10mins to ensure a gentle flow into the stomach. The feed should be given following an individual's length of time for a meal and their level of tolerance.

If syringing is too difficult add warm water to blend to loosen it.

Observe the child during administration of feed for indications of discomfort, stop or pause as required.

Once meal is completed flush with a minimum of 20mls to ensure no food is left in device.

Discard any leftover food and record amount given and any comments.

BLOCKED TUBE:

Don't panic!

Check blockage is not in syringe or extension by disconnecting from device and test, then flushing extension tube clear with water and prime again before reconnecting.

Try flushing gastrostomy device.

If gastrostomy blocked use a 60ml syringe with warm water gently push/pull repeatly to attempt to soften the food and move the blockage.

If a button device is completely blocked replace,

WASHING EQUIPMENT – This is the responsibility of person administering the blended feed.

Wash extension sets and syringes in warm soapy water and air dry

NOTE: Some plungers react with hot water and washing up liquid making them difficult to reuse. Blending equipment should also be washed in hot soapy water.

Appendix E

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	**Blended Feeding Policy** **Administrationof Liquidised Diet via Gastrostomy Buttons**

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs	**nil**	**nil**	**nil**
Training Staff	**nil**	**nil**	**nil**
Equipment & Provision of resources	**nil**	**nil**	**nil**

Summary of Impact:

Risk Management Issues:

Benefits / Savings to the organisation:

Equality Impact Assessment

- Has this been appropriately carried out? YES
- Are there any reported equality issues? /NO

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs	nil	nil	nil
Totals:	nil	nil	nil

Staff Training Impact	**Recurring £**	**Non-Recurring £**
Totals:	nil	nil

Equipment and Provision of Resources	Recurring £ *	Non-Recurring £ *
Accommodation / facilities needed		
Building alterations (extensions/new)		
IT Hardware / software / licences		
Medical equipment		
Stationery / publicity		
Travel costs		
Utilities e.g. telephones		
Process change		
Rolling replacement of equipment		
Equipment maintenance		
Marketing – booklets/posters/handouts, etc		
Totals:	**nil**	**nil**

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

Appendix

Equality Impact Assessment (EIA) Screening Tool

1. To be completed and attached to all procedural/policy documents created within individual services.

Document Title:	Blended Feeding Policy. Administration of Liquidised diet via Gastrostomy Buttons
Purpose of document	This document aims to provide parents, healthcare, education and social care providers with guidance and recommendations in how to support parents and carers in administering and maintaining a blended diet for their child/children. It is hoped that by providing information in a structured and evidence based way, families will be able to make an informed choice thus reducing risk and increasing patient outcomes. This document has been written in response to parental request and due to a generalised increase in interest in feeding children with a blended diet in the local area.
Target Audience	*Children and families who wish to administer liquidised feed and those profeesionals and carers who participate in meeting their nutritional needs.*
Person or Committee undertaken the Equality Impact Assessment	*Emma Woodfield. Childrens Community Nurse.*

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men			
	Women			

Race	Asian or Asian British People			
	Black or Black British People			
	Chinese people			
	People of Mixed Race			
	White people (including Irish people)			
	People with Physical Disabilities, Learning Disabilities or Mental Health Issues			
Sexual Orientation	Transgender			
	Lesbian, Gay men and bisexual			
Age	Children			
	Older People (60+)			
	Younger People (17 to 25 yrs)			
Faith Group				
Pregnancy & Maternity				
Equal Opportunities and/or improved relations				

Notes:
Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)			

Intended		

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:	
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:	
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	