Decompression Gastrostomy Tube in Acute Palliative Care Settings - Adult Only

Site Applicability

Richmond Health Services (RHS) Supportive Palliative Care Unit (SPCU) to be used in palliative care settings only.

Practice Level

1. Basic Skill
2. Registered Nurse (RN)

Policy Statement

1. Must have Physician's order for insertion of a Decompression Gastrostomy Tube. The Physicians order must Include:

    - Indication for tube insertion
    - Size of tube (large bore only)
    - Insertion of pre-procedural NG tube
    - Blood work (INR, PTT, Coagulation)
    - Patient Consent
    - Maintain NPO 8 hours prior to tube insertion

2. Physician's order required for:

    - Oral liquid diet
    - Continuous **low** suction and or
    - Intermittent suction and or
    - Drain per gravity
    - Tube irrigation

3. Decompression Gastrostomy Tubes are for drainage only; **do not provide feeds or administer medications through Decompression Gastrostomy Tubes**

4. Nurses must assess patency and external length Q shift and PRN

5. Peristomal skin integrity must be assessed Q shift and PRN

6. Irrigate tube as per Physician's order. Irrigate slow with 30-60 ml syringe

7. If an NGT has been in-situ for greater than 72 hours and output exceeds 1L/24H consider replacing with Decompression Gastrostomy Tubing

8. Patient and or significant other are in agreement with decompression tube insertion

Need to Know

- Decompression Gastrostomy Tube (also referred to as Venting Tube) is indicated for bowel obstruction resistant to medical treatment with refractory vomiting (vomiting that persists despite the administration of antiemetic's and antisecretory drugs)
- Decompression Gastrostomy Tube placement is a palliative care measure, considered as a last resort and as well as a replacement for prolonged Naso-gastric tube used for emptying of gastric content
- Improper care of Decompression Gastrostomy Tubes can lead to serious complications (see Major and Minor Complications Table)
- Decompression Gastrostomy Tubes and Feeding Gastrostomy Tubes are the same tube but they differ in function. Do not Misappropriate use a Decompression Tube for a Feeding Tube
- **When and if a Feeding Gastrostomy Tube is converted to a Decompression Gastrostomy Tube, the tube can no longer be used for feeds or for the administration of medications**
- For need to know information on irrigation, suction, gravity drainage, and wound care refer to Major and Minor Complications table Care

Indications

- Decompression Gastrostomy Tubing is indicated for:
    - Palliative care patients in their last few days or weeks of life
    - Bowel obstruction that leads to refractory nausea and vomiting that is no longer manageable by other medical means
- If an NGT has been in-situ for greater than 72 hours and output exceeds 1L/24H consider replacing with Decompression Gastrostomy Tubing

Contraindications

- Decompression Gastrostomy is contraindicated in patients for whom death is imminent

- Presence of one or more infections greatly increases the chances of complications and should be discussed with the multidisciplinary team and the patient/ patient's family

Major and Minor Complications

Major Complication	Signs and Symptoms	Prevention	Troubleshooting
Aspiration: May occur if tube migrates towards the esophagus or decompression is inadequate	• Aspiration pneumonia • Cough • Fever • Crackles upon chest auscultation	• Place patient in semi or high fowlers position for tube irrigation • Maintain low suction and or gravity as per Physician's ordered	• Notify Physician immediately • Position patient in semi fowlers • Obtain order for chest/ abdominal x-ray to confirm tube position
Buried Bumper (BBS)Syndrome: Occurs when the internal bumper of the g-tube becomes lodged between the gastric wall and the skin	• Severe Abdominal pain • Drain occlusion • Gastric ulceration	• Ensure external bumper is 1-2 cm from abdomen insertion site • Measure length of external tube Q shift and PRN • If a dressing is required place drain sponge over the external bumper **Note: Placing dressings between the external bumper and the skin can cause BBS syndrome**	• Medical Emergency notify Physician immediately • Stop suction • Do not irrigate the tube • Position patient in semi fowlers **Note: Removal and replacement of G-tube is done by Radiologist with physicians order**
Tube Dislodgement: Increased risk in confused or combative patients	• External tube length has changed more than 1cm • Complete dislodgment	• Ensure all connection are intact at all times • Ensure tube independent loop at all times • Avoid excessive manipulation of tube when cleaning tube • Do not tug or apply traction to tube	• Notify physician immediately, immature sinus tracts will close within 4 hours **Note: Removal and replacement of G-tube is done by Radiologist with physicians order**
Tube Misconnections: Increased risk in confused or combative patients Increase risk when using inappropriate tube connections	• Patient complain of Nausea and or vomiting Increase abdominal girth	• Do Not modify or adapt Gastrostomy Tube, suction tube, or catheter tube • Daily and PRN Assess and trace catheter from patient tube exit site to the point of origin	• Use the correct tube connection • If tube connection is leaking disconnect tube, clean tube tip of debris, and re attach • If leaking continues replace suction or catheter tubing

Minor Complications	Signs and Symptoms	Prevention	Troubleshooting
Superficial infection: Infection around the stoma site	• Stoma exit site reddened, warm, painful, and or swollen • Purulent, foul smell, and or discharge around the insertion site	• Cleanse insertion site Q shift and PRN when sinus tract is mature (after 7-10 days) • Obtain swab for C&S **Note: A single dose of antibiotics prior to insertion reduces risk significantly**	• Cleanse around insertion site Q shift and PRN x72h then Q daily and PRN x7 days and or until local infection cleared • Notify the physician • Notify wound care specialist • Obtain order for antibiotics
Leakage via Tube Insertion Site: Often occurs within the first few days post insertion	• Leakage of gastric contents around the tube exit site	• Cleanse around insertion site Q shift and PRN when sinus tract is mature (after 7-10 days)	• Cleanse around insertion site q shift and PRN x72h then Q daily and PRN x7 days and or until leakage is resolved • Apply barrier cream containing zinc oxide on peristomal skin • Treat any underlying fungal or bacterial infections with Physician's order • Notify wound care specialist **Note: Protect the healthy skin surrounding the exit site**
Tube Blockages:	• Partial blockage tube draining as well as leaking around the stoma exit site. • Complete blockage no drainage • Increase in abdominal girth • Patient complains of nausea and or vomiting	• Ensure all tubing connection are secure, ensure suction is on, ensure that there are no kinks in the tubing • Irrigate tube gently as per Dr order • Do Not use small size syringe as PSI is higher in small size syringe Use 30-60ml syringe • Do not administer feeds or medications through tube • If patient is permitted to eat comfort diet	• Complete blockage Stop suction • If blockage is visible attempt to dislodge by rolling tube between forefinger and thumb • Gently attempt to irrigate tube with room temperature water • If the blockage cannot be dislodged notify physician as the tube may need to be replaced **Note: Avoid using excessive force or sharp objects to dislodge**

		maintain patient on liquid oral diet as per Physicians orders • If tube is completely blocked, irrigate as per Dr order and or obtain an order for tube replacement.	**blockage. Use only large size syringe 30-60ml**
Hypergranulation: Granulation tissue is a proliferation of capillaries that forms in and around the stoma site	• Appears as a mound of red, moist tissue around the tube exit site • Tissue surrounding the stoma site is painful upon touch • Tissue surrounding the stoma site tends to bleed • S&S of localized infection, stoma exit site is reddened, warm, painful, swollen • Purulent, foul smell, and or discharge around the insertion site	• Maintain external bumper at 1-2 cm away from the stoma exit site • Avoid trauma to stoma site • Cleanse around insertion site q shift and PRN x72h then daily and PRN x7days and or until bleed and or localized infection are resolved • Obtain swab for C&S	• Obtain Physician's orders to treat any underline fungal or bacterial infections • Obtain Physician's orders for topical steroid in the absence of fungal or bacterial infection • Caustic preparations such as silver nitrate should be reserved as a last resort • Notify Wound Care Specialist

Pre-Insertion Requirements

- Patient Consent form signed for insertion of Decompression Tube
- Obtain Physician's order (refer to policy statement)
  - Insertion of Decompression Gastrostomy Tube
  - Pre-procedural antibiotics (at physicians discretion)
  - Insertion of pre-procedural NG tube

Pre-Insertion Patient Assessment

- Vital signs include: Temperature, Blood Pressure, Respiratory Rate, Oxygen Saturation
- Pain score (see appendix B)
- Monitoring for nausea and vomiting
- Level of consciousness
- NG tube is in situ and suction is maintained as ordered

Pre-Insertion Patient Preparation

- Educate patient and family re the purpose of the Decompression Tube insertion, what to expect, and what they should report on
- NPO 8 hours prior to Decompression Tube insertion
- Insert NGT 4h prior to procedure
- For Decompression Tube placement patients should
  - Be able to lie flat for approximately 20 minutes (procedural duration)
  - Be on no more than minimal oxygen therapy
  - Have blood coagulation within normal range
- Prophylactic IV antibiotics are recommended due to a high risk of post procedural infection
- The patient should be able to open their mouth at least 3cm for the placement of a mouth guard, if the decompression tube is inserted under endoscopy

Post-Insertion Patient Monitoring

- Monitor Vital Signs include: Temperature, Blood Pressure, Respiration Rate, Oxygen Saturation Vital Signs Monitoring Frequency:
  - Q 30 minutes x one hour and PRN
  - Q 4 hours x24 hours and PRN
  - Q shift and PRN
- Pain score (Appendix B) Q hour and PRN (on going until stable)
- Monitor nausea and vomiting Q hour and PRN (on going until stable)
- Dressing around the tube exit site (see below care and maintenance section)
- Tube drainage include: secretion color, amount and consistency

Equipment & Supplies

- Wound care supplies
  - Dressing tray
  - If Stoma is fresh or healing use normal saline to cleanse
  - If Stoma is healed use room temperature water and mild soap to cleanse
  - Cotton tipped applicator to cleanse bolster
- For irrigation
  - 30-60ml syringe for irrigation
  - Luke Warm tap water for flushing (consult Physician for flushing volume 10-50 ml)
- For Gravity drainage
  - Bolus Extension Set (Luer lock to catheter port See Appendix C for image)
  - Catheter bag and tube set
  - Safety pin and elastic to affix catheter tube to patients gown (do not puncture tubing
- For Suction drainage
  - Bolus Extension Set (Luer lock to catheter port See Appendix C for image)
  - Suction tubing
  - Suction container
  - Wall or portable suction unit
  - Safety pin and elastic to affix catheter tube to patients gown (do not puncture tubing)

Care and Maintenance

Diagnosis	Interventions
Stoma Site Care	• Cleanse stoma with normal saline and dress with simple dressing • Do not apply cream around the stoma exit site • Use a circular motion moving from the tube outwards • Clean sutures, external bolster and stabilizing devices using a cotton tipped applicator • Ensure stoma exit site is completely dry prior to dressing application • Dress the stoma exit site with a non-occlusive drain sponge over the external bumper. **Do not place dressings between the external bumper and the skin this can cause Buried Bumpers syndrome**
Cleansing the External Portion of the Gastrostomy Tube	• Use warm water and mild soap being careful not to pull or manipulate the tube • Cleanse from the insertion site and continue away from the patient stoma site • **If tube is a balloon Gastrostomy tube with an internal balloon**

	and external bumper rotate 360 degrees to prevent tissue in the stoma tract from adhering to the tube • **If tube is a Pigtail Multipurpose Drainage tube rotate tube gently to prevent dislodgement, make sure external length has not change after rotation and secure with statlock**
Irrigating Decompression Gastrostomy Tube	• Use room temperature tap water to irrigate • Use 30-60 ml catheter tip syringe (do not use smaller size syringe as this can increase pressure and potentially rupture the tube) • Do not use excessive force to flush tube this can perforate the tube and cause injury to the gastrointestinal tract • Irrigating volume 10-50 ml (Based on Physicians recommendations) • Irrigate every 8 hours or if sudden decrease in drainage amount • Verify Placement of the External Bolster • Verify that the external bolster rests 2-3mm away from the insertion exit site
Daily Measurement of the External Portion of the Decompression Tube	• **Prevent accidental dislodgment or BBS**

Expected Patient Outcomes

- Patient will experience resolution of refractory nausea and vomiting associated with malignant bowel obstruction
- Patient may be able to consume a liquid comfort diet (Obtain Physicians order)

Patient Education

- Physician/ RN to inform and educate patient and significant other re purpose of Decompression Gastrostomy insertion as well as educate what to report if the any of the following signs of complication occur
    - Stoma site is leaking, oozing, bleeding or appears otherwise abnormal
    - The appearance of the stoma sight suggests signs of infection
    - Abdominal pain, abdominal discomfort, abdominal tenderness, abdominal distension
    - Unexplained fever
    - Return or persistence of nausea and vomiting
    - Sudden change in drainage
        - Volume (volume may change based on how much liquid the patient is consuming but it should not stop)
        - Bloody or purulent discharge
    - If the centimeter markings on the external tube change more than 1cm
    - If patient has a bolster and it fits too tightly, is irritating or indenting into the skin
    - If the tube appears damaged or broken , or if there is leakage from any of the ports
- RN to Supply patient/ patient family with My Decompression Gastrostomy Information Sheet prior to discharge (Appendix A)

Evaluation

Signs and symptoms of nausea and or vomiting is resolved, tube is draining well by gravity and or low suction

Documentation

- Document in Kardex the date of insertion, site location, and external length of G-tube.
- Document drainage type and volume per shift
- Document in chart patient's response to procedure as well as teaching
- Document and report to the physician any signs of complications (see Major and Minor Complications Table)

Related Documents/Appendices

1. Your Decompression Gastrostomy Information Sheet (Appendix A)
2. Behavioral Pain Scale (Appendix B)
3. Gastrostomy Tube image (Appendix C)
    a. Balloon Gastrostomy Tube
    b. Universal Pigtail Drain
4. Bolus extension set image

References

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Developed By

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Reviewed By: Palliative Medicine Medical Director	**Date:** **November 19, 2014**
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Date of Approval/Review/Revision

YOUR DECOMPRESSION GASTROSTOMY INFORMATION
(Keep this information sheet for future reference)

Your Name _____

Your Phone #_____

Doctor Who Inserted the Decompression Tube: _____

Date the Decompression Tube was inserted_____

Home Care Phone # _____

Tube Specifications

Decompression Tube Type_____

Tube Size_____ French

Original Tube length _____ CM

External tube Length _____CM

How to Care and Maintain My Decompression Tube

Maintain the site around the tube clean and dry at all times if possible.
Your home care nurse will teach you how to change the dressing around the tube.
Draining by Gravity your home care nurse will provide you with teaching and a list of supplies that you will need to have.

Flushing Specifications

Your Home Care Nurse will teach you how to flush the tube

Irrigate with room temperature water using a 30-60 ml syringe

Do not use excessive force

Irrigate with 20-50ml of tap water

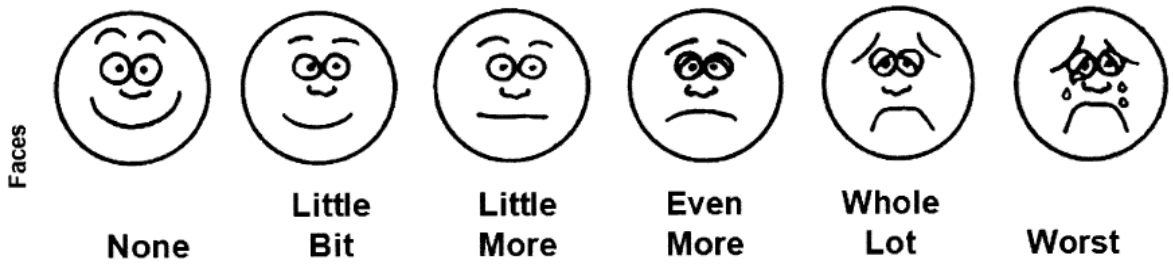
Eating or drinking- It is recommended not to eat food that may block the tube. Consult with your Doctor about liquid diet

B) Pain Scale

If patient can communicate, use 0 to 10 Numeric Rating Scale (NRS):

0	No pain
1to 3	Mild pain
4 to 5	Moderate pain
6 to 7	Severe pain
8 to 9	Very severe pain
10	Worst possible pain

If patient is unable to use the numeric pain scale but is able to communicate, use the Faces Pain Scale:

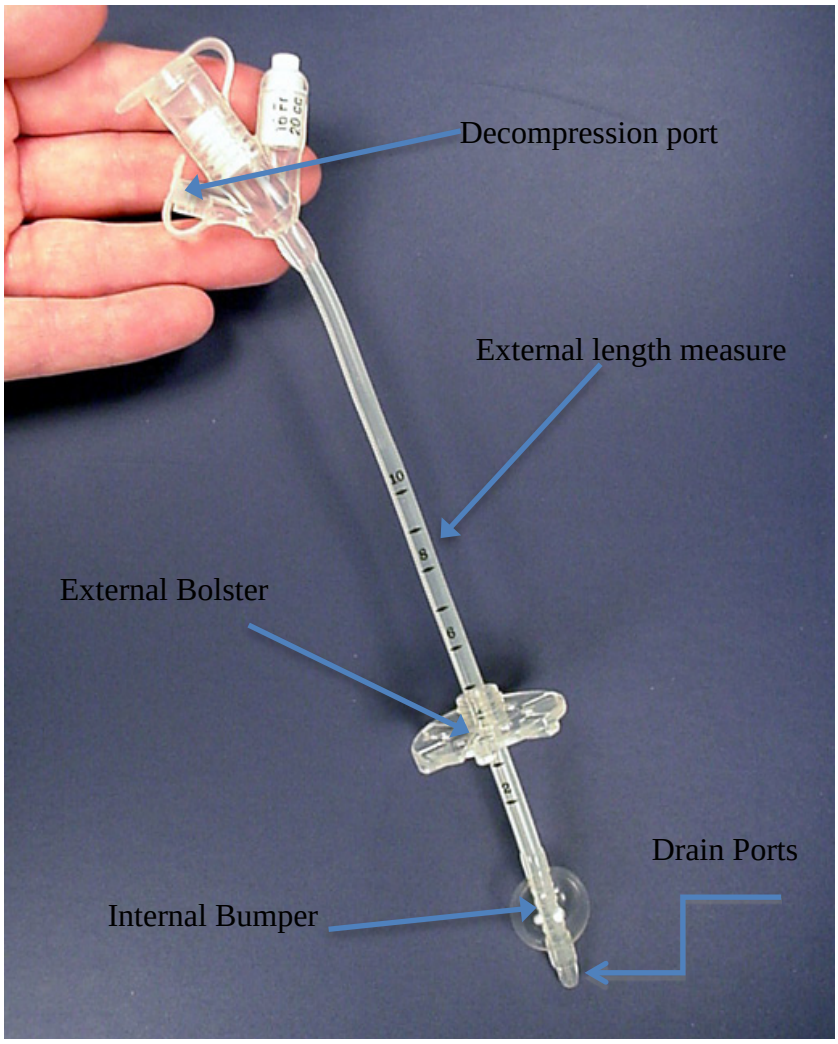


If patient is unable to communicate, use the Behavioral Pain Scale (BPS):

Observation	Description	Score
Facial expression	Relaxed Partially tightened Fully tightened Grimacing	1 2 3 4
Upper limbs	No movement Partially bent Fully bent with flexation of fingers Permanently retracted	1 2 3 4
Compliance with ventilation	Tolerating movement Coughing Fighting ventilator Unable to control ventilation	1 2 3 4

C) Gastrostomy Tube Image

a) Balloon Gastrostomy Tube



b) Universal Pigtail drain image