

SURVEY OF CAPHC CENTRES  
**PEDIATRIC GASTROSTOMY TUBE MANAGEMENT**  
 October 2006

	St. Joseph's Health Centre, Toronto	Children's Hospital of Western Ontario, London Health Sciences Centre	Ottawa Children's Treatment Centre	IWK Health Centre, Halifax	Centre hospitalier universitaire de Sherbrooke	Kingston General Hospital, Kingston, ON	Northern Alberta Pediatric Home Nutrition Support Program	Orillia Soldiers' Memorial Hospital, Orillia ON	Winnipeg Children's Hospital	The Hospital for Sick Children, Toronto	Janeway (Chief of Surgery / Charge Nurse Surgery), St John's NF	Alberta Children's Hospital	John McGivney Children's Centre, Windsor ON
Is your facility using a clinical pathway/care map for the care of children with a gastrostomy tube?	No	NO. We have a teaching booklet & a patient education checklist that we follow. Three different types of tubes are placed: Balloon gastrostomy, percutaneous & percutaneous endoscopic G tubes. One surgeon will attempt to place laproscopically a low profile tube in the operating room.	No	No	Yes	There is no clinical pathway/care map available at this time.	no	Not at this time	No	Not formally, however there is one currently being developed for care on the day of admission.	Yes	No.	No
Does your facility have a key resource person for questions/managing GT problems during the daytime?.	No	Yes. Nurse Practitioner. We also have a multidisciplinary (Nurse Practitioner,	Any of the nurses can be a resource, also CHEO GI nurse can be consulted	The Discharge Planning Coordinator and the Enterostomal Therapist	Yes	Yes, the enterostomal therapy nurses.	yes, the Home Nutrition Support Nurses	No, we consult the hospital for sick children if necessary	No. Yes – the person who inserted it. There are several people the	Yes, myself and a Registered Nurse who has the title "G-tube resource	No – the Charge Nurse on Surgery does it by default but to date funding for a	Yes, home nutrition and surgery clinic nurses	Not directly employed by the John McGivney Children's Centre.

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	Dietitian, Occupational Therapist) Enteral Feeding clinic once per month for the outpatients who wish to attend. A Gastroenterologist is available for referral if needed.	who does use a critical pathway						family could call: surgeon, Dr. Rempel, MHNP nurse, Surgical NP	nurse"	proper resource has been denied. / A job description for a specialty nurse position has been drafted. This role, if funded, would include the teaching and care for this group of children.		Services are provided through the Community Care Access Centre (nursing services). Families receive direction from pediatrician, family physicians or nursing care CCAC or private insurance. Gastrostomy tube management at our facility is not addressed directly by staff members. The John McGivney Children's Centre does not employ nurses at

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												<p>this time. This issue is managed by a client's pediatrician, family physician and or nurses in the community. When an issue arises at our facility with a client, the client's parents are contacted and or a nurse through the Community Care Access Centre or private insurance if applicable. The nurse communicates with the client's doctors as necessary. For children</p>

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													who attend preschool or school at the JMCC, CCAC nurses provide care for the children.
Does your facility have a key resource person for questions/managing GT problems during nights/weekends?	No	No	No	General Surgery on-call physician staff respond to inquiries re problems with enteral devices	No It's the pediatric unit nurses who has the ability to answer	No	Home Care does a lot of this within Edmonton, otherwise it would be local hospitals or emergency departments	No, same as above	No Yes – the person who inserted it. There are several people the family could call: surgeon, Dr. Rempel, MHP nurse, Surgical NP	Unfortunately, no.	No – Funding denied.	No, other than the surgeon on call	No
How do families in your facility access supplies?	Via Sick Kids	Ordered by NP after tube insertion, using Assistive Devices Program (ADP) from authorized vendor in client's home area.	Through their vendor and their family doctor are responsible in renewing the ADP form	Supplies are funded through the Department of Health as part of a global budget if private insurance, Community Services and In-Home Support are not involved with the family. Discharge Planning will	CHUS or pharmacy or CSSS or ministerial program	Supplies are provided by the hospital when the child is an in-patient. Otherwise, supplies are provided by Community Care Access Centre and/or are purchased directly from a medical supply vendor.	from the Home Nutrition Support program-families on the program order supplies monthly from an off site warehouse.	? Homecare. If necessary we can provide supplies if an emergency situation	Home Care usually (if biological guardians). Through community pharmacy with a script if guardian is through CFS	We have a Specialty Food Shop on site the is the vendor for the majority of our patients	Via prescription. If on Social Services, via provincial supply.	They order them and then depending on if they are in the city or out of town, they will pick them up here or have them mailed out.	N/A

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				correspond with these agencies and negotiate on behalf of the family. Supplies provided by Discharge Planning and funded by the Department of Health are provided in predetermined amounts. These supplies can be picked up at the Health Centre or they can be mailed out or sent by bus.									
Are there different funding sources for supplies?	Don't know	Yes. ADP cover ~ 75% of authorized equipment & supplies. 25% patient's responsibility. May also qualify for assistance to Children with Severe Disabilities (ACSD) to cover other 25% (income	ADP & personal insurance/ special request through foundations	See above	Insurance company or ministerial program or cancer society	Assistive Devices Program (ADP), Assistance for Children with Severe Disabilities (ACSD) and private medical insurance plan	yes: NIHB, Family Support for Children with Disabilities, Child health benefit Program, Alberta Works	Unsure	Yes	Yes. There is an Ontario Government plan called Assistive Devices Plan (ADP) that covers 75% of the costs associated with supplies. We encourage families to liase with our social	Yes	Our supplies are 100% paid for by the gov't	N/A

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		based < \$62,000 per year). Patient's own private extended health benefit coverage.								workers to identify other funding sources if needed. There is also the plan: Assistance for Children with Severe Disabilities (ACSD) that may cover the remaining 25% of the costs, but family incomes must be less than 60,000 to qualify.			
At what time do you change to a low profile device?	We don't [refer to a tertiary care centre]	3 months.	We do not change G-tubes. Our centre relies on the pediatric hospital surgeons	Low profile devices are usually inserted after 3 months	6 to 8 weeks or 3 months for the enteristar and bard system	Six weeks post-insertion, providing the site is healthy and clean.	with a surgical g-tube after 4-6 weeks, with a PEG after 3 months	This would be a tertiary level function	No specific time. Three months post-op	We ask families to contact us around the 4 month mark to arrange for a tube change in our clinic if they are not doing it themselves. We have some tubes that are successfully in place for up to 6 months.	When persuaded to. Not as my plan.	Depends on the surgeon. Two surgeons wait for 6 months and the other 2 will fit for a low profile device in 6 to 8 wks.	N/A
What are your facility's	N/A	3 months.	N/A	Everyone is	Easier to live	All long-term	basically all	None	This is my	1. We carry	If excess	As above	N/A

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criteria for insertion of a low profile device?		Balloon G tube in situ, size 12 or 14 Fr.		given the option of a low profile device, either a Bard Button or a balloon device.	with when you are a child Less risk than the feeding tube	G-tubes are changed to low-profile devices with parent's/care giver's consent.	the children get one unless it is contraindicated	available at this time. Would consult hsc	standard of care for all GTs. No specific criteria	<p>devices beginning at 12FR, so we request the stoma be able to accommodate a tube of this size. This often requires a tube size increase of the original tube to gently dilate the tract.</p> <p>2. The initial tube must be in place for at least 8 weeks to allow for complete healing</p> <p>3. the family must demonstrate</p>	leakage in non low profile. If delays in pulling out regular device.	and how much venting does the child require. We do not recommend going to a low profile device is venting needs are significant.	

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										rate competence and commitment to the care of the device 4. Of course, it is essential to determine the device would actually benefit the child			
What % of your population receives a low profile device?	Don't know	All children with # 12 or # 14 G tubes may be switched. Probably 95 % of G tube fed children receive a low profile tube .	Of the clients who have a G-tube 98% receive a low profile device	Approximately 80%	100%	95% (estimated)	of the children with g-tubes: 95 %	?	25% - 100%	Just an estimate, but likely >60%	Less than 5%. / Mostly CF patients	I'd say almost 100%	N/A
Which company does your facility order GT tubes from?	N/A	Products used for low profile are MIC-Key G tubes (bard product) & Nutriport G tubes. Parents order from their	N/A	PEG's and "Bard Buttons" are purchased from Bard, and we are currently using the MicKey balloon	Kendall (nutriport and enteristar) Kimberly clark (mickey) Bard	Bard, Dawson-Mueller, Cook, Kimberly-Clark, Kendall, Medi-Tech	Kimberly-Clark-MIK-key skin level; TYCO-Nutriport	Various	MIC-KEY, BARD	Our initial tubes are COOK Mac-Lock gastrostomy tubes, which are inserted in radiology If the tube is placed in the	MIC	Kimberly Clarke for MIC and MICKEY Bard and Kimberly Clarke for pegs enteristar low	N/A

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		equipment supplier. In hospital we use Dumex balloon G tubes.		device from Kimberley-Clarke						OR by a surgeon, the tube may be a MIC balloon tube. If the tube is a GJ, many of our infants have a CAREY-ALZATE tube		profile	
Does your facility use a gastrostomy tube smaller than a 12 FR? If so, what company makes it?	N/A	Yes. Percutaneous G tubes may be 8.5, 10 or 12. The company is Cook.	None of clients presently	No	No	Some of the percutaneous tubes might be sizes 8.5 and 10.2 FR. These tubes generally are from Cook, Dawson-Mueller and Medi-Tech.	no	Yes, a #10	Usually no, unless it is a very small baby. No.	We will use a variety of tube sizes, particularly for infants. Our sizes range from a 6FR to 14FR	No	no	N/A
What is your facility's recommendations for 'unblocking' a gastrostomy tube at home?	Coca-cola	Pharmacologically unblocking with 325 mg Sodium Bicarbonate tablet crushed + contents of pancrealipase capsule + 15 ml water. Instill in tube, wait 5 minutes & attempt to flush. A diet soda drink	We use the pediatric hospital guidelines, usually referred to Enteral-osteomy Nurse @ CHEO	Warm water in a syringe and use a "rocking" motion to try to dislodge the blockage. Also some families will use cotazyme and sodium bicarbonate combination	None Does not happen frequently Really rare	Parent's/care givers are instructed to clear the tube with warm water or a carbonated drink using a push-pull technique with a 60-cc catheter-tip syringe	warm water;	Parents have been known to use soda Pharmacy protocol-include	Diet coke, diet cranberry juice. Water irrigation under high pressure.	Our patients are given a handbook describing the interventions for unblocking tubes. These include: Using the smallest syringe possible for the greatest pressure (avoiding luer-lok	(1) Prevention (2) Irrigate with Diet Pop (3) Instill with Cranberry Juice (4) Use of Pancreatic enzymes	we do not have a real policy re: this. Some of the surgeons still want to use coke! We have used the pancreatic enzyme/baking soda concoction with good success.	N/A

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		can be tried to unclog the tube . Flushing the tube with warm water when it seems to be plugging also works well .								syringes, so that if the pressure is too great, the slip tip syringes would just pop off and not break the tube) removing all adapters or extension devices instill-withdraw technique using warm water if no success, attempt to instill sodas or pulp-free OJ and leave in tube for 15 min, then with draw and flush with warm water If no success, they come to hospital for a tube check and change		We rarely have gtubes that plug	
What are your facility's recommendations for frequency of changing balloon gastrostomy at	N/A [advice given by our tertiary care centre]	When the balloon is broken or tube	Q3months if no issues with G-tube to change	They are taught to check the balloon at	When we have a leak or a dysfunction	There is no regular schedule. The tube is	Parents have a spare, they change it when it	Recommend ations are given to parents by	3 times a year. Only if balloon	Our families are advised to check the balloon fill on	Only when can't be unblocked, falls out, or	We change only as necessary ie: the valve	N/A

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home?		malfunctions or 3-4 times per year	PRN as per CHEO's protocol	least weekly and if the water from the balloon contains formula or has greatly diminished in volume they change it. There is no predetermined time and some last a month and some much longer.		changed only in cases of balloon rupture or tube dysfunction.	breaks. We don't have a set schedule. We expect MIC-keys to last 4 months	the hsc upon insertion	breaks.	a weekly basis and notify us if there is a discrepancy that may require the tube to be changed. Many families do change the tubes themselves and we give them the same advice as if they were to come to clinic –start thinking about changing the device at 4 months, and stretching it no longer than 6	balloon breaks.	is leaking more and more	
When does your facility recommend GT dressings?	N/A see previous	Open to the air clean & dry. Aqua cel dressing if drainage.	Referred to ped Enteral-ostomy nurse	Dressings are only recommended if there is drainage from the site or if the flange is irritating the peritubular skin	During the first days after the installation	The dressing is removed 24 hours post tube insertion. The site is left open to air. There is no dressing unless there is excessive drainage from the peri-	we use a special dressing for hypergranulation tissue, We usually suggest g-sites be left open to air with no dressings	If frequent leakage or skin breakdown	When there is plus moisture at site. None needed usually.	Not beyond the first 2 weeks Only if we have treated granulation tissue with silver nitrate or if there is an excessive amount of drainage and skin	When dirty.	If the site is leaking a lot, then we may recommend the use of a 2X2 gauze under with frequent changes.	N/A

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						tube area.				breakdown			
If recommended, what type of dressing (generic name) (example gauze, foam) is used?	N/A	Usually aquacel dressing.	Referred to ped Enteral-osteomy nurse	If there is no underlying pressure area or other type of open lesion the usual recommendation is to use a 2x2" gauze or to use the small round make-up remover pads (100/pkg for approximately \$1). These are economical and stay in place easily without tape. We have also used Allewyn foam, mepilex lite. It is very dependent on family circumstance and anticipated compliance.	Gauze 4 X 4	Plain gauze Hypertonic gauze (i.e. Mesalt)	as above	DEPENDS ON REASON Gauze Trach dressings (split)	? Gauze. Foam (allevyn), aquacel.	In the first two weeks it is regular 2x2 guaze If the event of significant skin break down we may recommend short term use of Allewyn dressing cut into a square and placed around the tube	Jelonet when leaky sit. Dry gauze for granulation.	Regular 2X2,	N/A
What is your facility's recommendations for treating skin breakdown around gastrostomy?	No policy	Protect skin with a barrier cream at all times when there is potential for	Referred to ped Enteral-osteomy I nurse	This is very dependent on what is causing the breakdown. If the	Proshield creme or a mix of stomahesive and pâte d'ihle	Cleanse with warm water twice a day. Leave open to air. No topical	Barrier cream -stoma powder. Address the source of the skin	No specific protocol	Local skin care (soap and water wash, keep dry), polvsporin or	Barrier cream (non petroleum base) and Allewyn if necessary	Keep dry, eliminate leakage. / If tube is leaking, instill ileonet	Freq skin care of cleansing with water, dry and	N/A

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		skin breakdown.		breakdown is a pressure area it is treated as any other pressure wound. If it is irritation from drainage we have recommended everything from Maalox, proshield, criticaid, crusting with premium powder and 3M no-sting barrier film, and others.		ointments or creams to site.	breakdown i.e. leakage, infection		nystatin for infections. Barrier cream, sucrolfate cream.	Clean with soap and water, keep it dry NaCl compresses when appropriate to shrink granulation tissue	around G-tube	then apply thin layer of calmoseptin e cream as a barrier prn. If leaking is from a gapping stoma, have used stomahesiv e powder down tract to make a "plug"	
How does your facility treat granulation tissue?	No policy	Silver nitrate stick + aquacel dressing.	Referred to ped Enteral-osteomy nurse	Granulation tissue is most frequently treated with silver nitrate sticks and families are taught to use them properly. Occasionally we have used Kenolog ointment but very rarely	Application of nitrate d'argent	Silver nitrate twice a week Mesalt dressing daily and as needed	we do both silver nitrate treatments and foam dressing. Decrease friction at the site	Moist dressings Silver nitrate sticks for hyper granulation	Silver nitrate sticks if bleeding or if increasing in size otherwise just observe. Cautery, ligation, observation.	NaCl soaks tid- qid x 3-5 days and reassess If no improvement, may use Silver Nitrate to cauterise the tissue	Leave it alone. / silver nitrate	Use silver nitrate sticks	N/A
What is your facility's recommendations for prevention/intervention of fungal infections?	No policy	Keep area clean & dry, no gauze dressings.	Referred to ped Enteral-osteomy nurse	Prevention is encouraged by using barrier	Doctor's recommendat ion???	Keep site clean and dry and open to air.	keep site dry, use of antifungal ointment after	No dressings routinely	None. Just good skin care.	Prevention: no dressings, clean with soap and	Mycostatin powder.	Use of calmoseptin e cream	N/A

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		Treat with Nystatin cream usually.		creams and absorptive dressings if drainage is present. If fungal infection is present canesten or nystatin are frequently used			a positive culture			water, act prompting if the site changes in appearance Treatment/intervention: Canesten cream or the like		mixed with mycostatin powder. Apply thinly BID.	
What is your facility's recommendations for prevention/intervention leakage of stomach contents around the tube?	No policy	Check balloon weekly. Minimum 3 ml water in balloon. Accurate assessment of skin level tube length. Keep disc of balloon G tubes ~ 2-3 mm above the skin, prevent disc from moving/migrating up the tube.	Referred to ped Enteral-osteomy nurse	Ensure that device placement is correct and that tube is appropriately secured to prevent migration. If it is a balloon device inflation of tube is checked. If the leakage cannot be totally prevented then ensure that a barrier product is used and that a dressing to absorb drainage is also used	None	Check the following: tube size, tube stability and tube fit.	proper fit of tube, smaller more frequent feeds, venting of g-tube to decrease pressure, regular bowel routine	Proper placement, investigation	Change tube to a MIC-KEY, add water to the balloon (if able) and push down on the outer disc/bar. Proper tube care and positioning, balloon over-inflation and flange tension.	Prevention: no dressings, keep the sites dry from the beginning, no lotions, rotate the tube a small amount each day to a new position (never from side to side which may stretch the stoma)  Intervention: saline compresses, tube placement checks, alleevyn dressings if indicated, possible change of	Keep tube as still as possible. It big leak, pack with Vaseline gauze. Transiently change to smaller tube. Let hole shrink. Then replace original size. / Prevention keep balloon inflated adequate and keep disc close to skin. Leakage instill jelonet around tube of G-tube site.	Prevention: ensure balloon volume is adequate, check balloon weekly and prn. Ensure that bolster is snug. Ensure low profile device fits adequately  Intervention: use of cream as above. Remeasure low profile device if necessary. Tape	N/A

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										device (eg. From original tube to a button may give a more snug fit as you can adjust the fill on the balloons), inflate balloon with a little more water		bolster down to abdomen to keep a seal if too soon to change device entirely.	
What is your facility's recommendations for prevention/intervention skin breakdown or ulceration around stoma?	No policy	Barrier cream, Calmoseptine often used. Cavilon barrier used in hospital. Secure tube to abdominal wall to prevent excess movement, pull on the tube . Sometimes use burn netting .	Referred to ped Enteral-osteomy nurse	Have already discussed breakdown from drainage. For prevention of ulceration encourage daily assessment under flanges. The circular, saucer type flange on the Wilson-Cook G/J tube is especially problematic and families are encouraged to keep a dressing of some type under them	Same as treating skin breakdown	Same as treating skin breakdown	proper fit of tube, treat the source of the problem-infection, leakage. Use of barrier cream, antibiotic ointment, stoma powder,		Specific script for infection (? Fungal), skin barrier product. Education.	Same as above, keep it dry and well secured Avoid tapes that cause sensitivity or irritation	As per general stoma care. Independent of gastrostomy.	Prevention: limit leaking, see #18 as above  Intervention: see #15 and 16 above Also is device too tight causing ulceration	N/A

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				at all times.									
What is your facility's recommendations for prevention/intervention abdominal pain during infusion of feeding?	No policy	Vent before feeding. Slow feeding down. Pause feeding if pain occurs. Be sure child is stooling daily.	Stop feed, assess the child, vent; resume feed after 15-30 mins. Re-evaluate. If still experiencing pain stop feed inform parents and they should follow up with their dietician and family physician. We are an out patient Rehab centre. Thus we rarely have fresh G-tubes or post op patient.	Feeds are not given with the patient lying flat. Also if pain occurs during feeding volumes and rates are reassessed and some manipulation may occur before final feeding goals are achieved. (i.e. May need gradual progression to a bolus type feed)	Doctor's recommendation ???	Ensure that there is no introduction of air in system i.e., prime the lines Slow down the rate of infusion Ensure regularity of bowel elimination.	venting of tube if gas, bowel routine, look at feed schedule-volume and rate of feed	Slower rate of feeds Small frequent feeds Ranitidine	Decrease the rate of the feed infusion. Slow the infusion, consider changing the tube, zylcaine jelly.	I wouldn't say we have a specific policy on this issue but what we would examine is determine the origin of the pain Tube placement checks If it is an intolerance to volume issue, we may advise the families to slow the feeding down or to vent the tube	Slow down feed/ or feed according to pt tolerance. Burp tube. One week for actual cause of pain.	We don't usually have problems with pain during feeds. Vent prn, slow rate of feed, do they need a pump to manage bolus delivery, would the use of cont overnight feeds make daytime boluses smaller and therefore more tolerable etc.	N/A