Somerset
NHS Foundation Trust

Somerset Guidance for Patients with Inoperable or Irreversible Malignant Bowel Obstruction

Guidance

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<table>
<tr><td>Document Author</td><td colspan="3">Jo McAndie- Palliative Care Clinical Nurse Specialist</td></tr>
<tr><td>Lead Owner</td><td colspan="3">Jo McAndie-Palliative Care Clinical Nurse Specialist</td></tr>
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I would like to take this opportunity to thank everyone in the Supportive and Palliative Care Team, as well as Dr Catherine Leask, who have all supported me in writing this guidance, thank you.

1.0 FLOW DIAGRAM

Guidance for Inoperable or Irreversible Malignant Bowel Obstruction

Abdominal examination with digital rectal examination/X-ray/CT as appropriate, to differentiate constipation or paralytic ileus.

Bloods (if able) U&E's, FBC, LFT's, CRP, Corrected Calcium, Magnesium and Lactate.

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If confirmed malignant bowel obstruction without any surgical/interventions, continue:

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1. Symptom control with regards to pain, nausea and vomiting, oral care, and bowel management- **Please see guidance overleaf.**

2. Unless any contraindications, S/C Dexamethasone 3.3mg BD (8am/2pm) for 5-7 days then review. (Please give first dose on admission).

3. If vomiting, share decision with patient for consideration of NG tube insertion (Ryle's tube) ***for drainage only, NOT for feeding/medication/hydration.*** – **Monitor output**.

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'**What is important to the patient**?' Honest conversation with patient and those important to them with regards to STEP, likely prognosis, supplementary fluids and role of parenteral nutrition (pn) (pn unlikely to be appropriate- please see pn policy or contact nutritional team Mon-Fri via bleep 3392/3394).

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Discharge Planning including- OT/Physio review with realistic goal setting.

Structured handover to District Nursing Team if NGT ***(for drainage only, NOT for feeding/hydration/medication)*** is to remain in situ on discharge **(Ward to action please- See Appendix A&B for guidance).**

JIC medication with completed white community Palliative Care MAR Chart.

Plan if NGT requires re-insertion once discharged. **Mon to Fri (8am-4pm)** please inform patient to contact **ESAC** at MPH on **(01823) 343062** *OR* if living in West Somerset area, patient can contact **Williton Hospital** on **(01984) 635665 daily (9am-5pm)**. ***Patient must self-refer prior to attending either site.***

Plan for who will medically manage the patient once discharged e.g.GP, have they agreed to this?

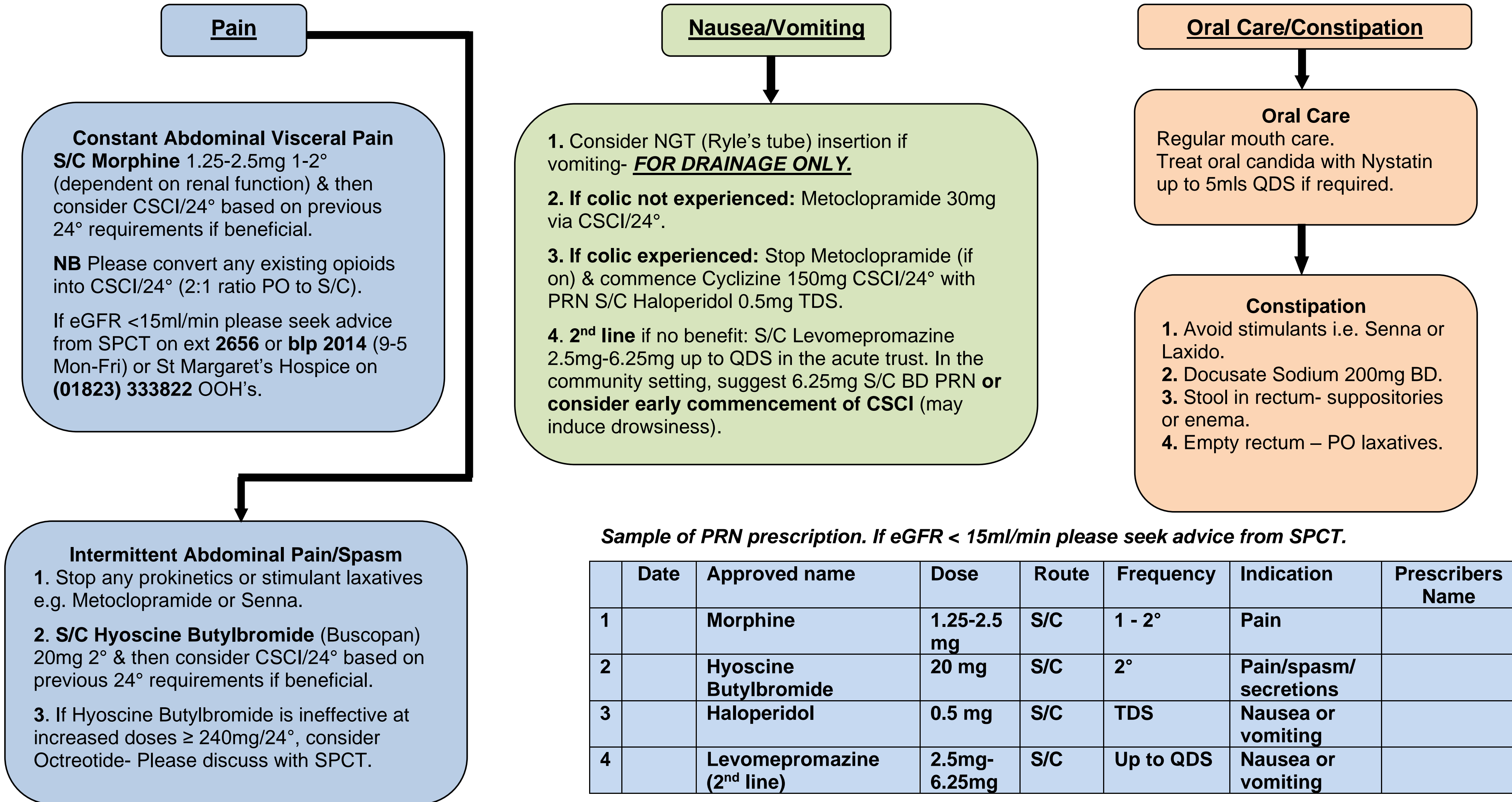
STEP/LLI discharge summary/ACP must be completed, including guidance/plans for above. Please document who is responsible for which action.

Referral to St Margaret's Hospice on discharge with patients consent on **(01823) 333822 (ward to action please)** for community support, or OOH's symptom control whilst an inpatient.

Please ensure all the above is documented in the discharge summary/on EPRO.

Symptom Control Management of Malignant Bowel Obstruction

Unless any contraindications, please prescribe S/C Dexamethasone 3.3mg BD (8am/2pm) for 5-7 days.



Sample of PRN prescription. If eGFR < 15ml/min please seek advice from SPCT.

	Date	Approved name	Dose	Route	Frequency	Indication	Prescribers Name
1		**Morphine**	**1.25-2.5 mg**	**S/C**	**1 - 2°**	**Pain**	
2		**Hyoscine Butylbromide**	**20 mg**	**S/C**	**2°**	**Pain/spasm/ secretions**	
3		**Haloperidol**	**0.5 mg**	**S/C**	**TDS**	**Nausea or vomiting**	
4		**Levomepromazine (2nd line)**	**2.5mg- 6.25mg**	**S/C**	**Up to QDS**	**Nausea or vomiting**	

SPCT available Monday to Friday (9-5) ext: 2656, bleep 2014. For any OOH's symptom control advice contact St. Margaret's Hospice on (01823) 333822

2.0 INTRODUCTION

2.1 This guideline applies to all patients presenting with inoperable or irreversible MBO, whether they are in MPH, a community hospital or in their own home.

2.2 The aim is to improve the medical management of patients diagnosed with MBO and their care and management if/when discharged from the acute trust. Additionally, it is to ensure equity regarding delivery of care for symptom control.

2.3 MBO is a well-recognised complication of both advanced abdominal and pelvic cancers, with sadly, a median survival rate of weeks to short months (Winner et al 2013).

2.4 The term bowel obstruction encompasses a range of clinical situations, making diagnosis challenging. The obstruction can be intermittent or permanent, complete, or partial and acute or chronic, occurring at any site along the gastrointestinal tract.

2.5 Surgery is not always feasible due to high postoperative morbidity, mortality, and re-obstruction rates, therefore, resulting in complex symptom management combined with an unpredictable trajectory (Daines et al 2013). Nevertheless, where appropriate, a surgical option should always be considered as part of the patient's management, as in certain situations (i.e. single lumen obstruction for instance), a positive outcome post-surgery could be achieved.

2.6 The obstruction, which can affect either the small or large bowel due to extrinsic (i.e. adhesions from previous surgery causing kinking of the bowel, or carcinoma or inguinal/ umbilical hernias compressing the bowel) or intrinsic (i.e. bowel wall thickening becoming compromised, causing/developing a stricture from Crohn's disease for example or volvulus) aetiology, gastrointestinal malignancy or functional occlusion, prevents the transmission of both oral diet and fluids. Therefore, the oral route for diet, hydration, or medication, is not suitable due to nausea or vomiting and impaired absorption through the gut.

2.7 The individual management/treatment options must include a clear understanding of the patient's wishes, to ensure their considerations are listened to and heard. This will ensure symptoms are managed to a level that enables the patient to be discharged to their preferred place of care if appropriate.

2.8 If the plan is to discharge the patient out of the acute trust, a detailed strategy should be considered, to prevent re-admission if that is the correct option. Discharge plans must include, STEP/LLI discharge summary (ACP), JIC medication with completed white community Palliative Care MAR Chart, referral to St Margaret's Hospice for OOH's symptom control advice (with patient consent) and a plan for a person benefiting from NGT ***(for drainage only, NOT for feeding/hydration/medication)*** in the community if that has been agreed. Sensitive discussions around preferred place of care/death are encouraged, incorporating FTCHC support (FTCHC team are contactable via bleep 7755).

3.0 ABBREVIATIONS

ACP - Advance care planning
AHP's - Allied health professions e.g. Occupational therapists/physiotherapists
BD - (Bis die sumendum) Twice daily
Blp - Bleep
BNF - British National Formulary
C/O - Care of
CSCI - Continuous subcutaneous infusion

CT - Computerised tomography
DNs - District nurses
eGFR - Estimated glomerular filtration rate
EOL - End of life
ESAC - Emergency surgery ambulatory care
FTCHC - Fast track continuing health care
GP - General practitioner
Hrly- Hourly
I/V - Intravenous
JIC - Just in case (medication)
LLI - Life limiting illness discharge summary
MAR - Medication administration record
MBO - Malignant bowel obstruction
MPH - Musgrove Park Hospital
NGT - Nasogastric tube
No'- Number
OOH's - Out of hours
PCF - Palliative Care Formulary
PN - Parenteral nutrition
PO - Oral administration
POC - Package of care
PRN - (Pro re nata) As required
S/C - Subcutaneous
SPCT - Supportive and Palliative Care Team
STEP - Somerset treatment escalation plan
TDS - (Ter die sumendum) Three times daily
QDS - (Quater die sumendum) Four times daily

4.0 ROLES and RESPONSIBILITIES

SPCT: Provides specialist advice regarding symptom control, as well as EOL care for patients with a life limiting illness.

DNs: Provide care and support for patients in their own home and those important to them.

St Margaret's Hospice: Provides 24hr telephone symptom control advice on **(01823) 333822,** as well as community support in patients homes via face to face review from community palliative care nurses.

5.0 PROCESS DESCRIPTION

5.1 MBO may be suspected if there is abdominal distention, pain, nausea and or vomiting, diarrhoea, or constipation +/- absence of rectal flatus. (NB: Patients can experience diarrhoea in partial obstruction).

5.2 Diagnosis of obstruction is made by a thorough medical history, a physical examination including a digital rectal examination, combined with radiological imaging such as an X-ray or if indicated and absolutely needed, abdominal CT to rule out any differential diagnosis such as constipation or paralytic ileus.

5.3 Symptoms commonly associated with an obstruction frequently include, abdominal pain/distention, abdominal colic, nausea and/or vomiting or large volume vomit (emesis) with excessive gastrointestinal secretions. Frequent emesis can lead to fluid deficiency and electrolyte imbalance making symptom control imperative.

5.4 In **proximal obstruction** (stomach, duodenum, pancreas, jejunum), vomiting is commonly experienced and can be frequent with large volumes.

In **distal obstruction** (large bowel), symptoms gradually develop, with prominent abdominal distention.

Symptoms such as nausea, abdominal pain including colic and xerostomia (dry mouth) may be experienced irrespective of level of obstruction.

5.5 If obstruction confirmed, consider commencing a fluid balance chart, recording appearance, frequency, and volume of vomit. Additionally, record volume and frequency of urine output and bowel output if profuse liquid stool.

5.6 Consider if catheterisation is required for fluid balance/management.

5.7 Consider commencing a food chart if patient is eating and drinking. Most patients will be sufficiently hydrated with sips of oral fluid combined with regular effective oral care, however, if persistent thirst is experienced, parental fluids could be considered.

5.8 Symptom management- as per flow charts on pages 3 and 4.

N.B- With all suggested medication, please review BNF/PCF for any indications/ cautions/interactions/side-effects prior to any prescribing.

<u>All suggested medication is via S/C route due to concerns regarding absorption +/- nausea and vomiting.</u>

Unless any contraindications, prescribe S/C Dexamethasone 3.3mg BD (8am/2pm) for 5-7 days (equivalent to 4mg BD PO). This is to aid reduction of inflammation as well as oedema around the tumour site, hoping to relieve pressure on the bowel. Dexamethasone should be reviewed for discontinuation after 5 days if no relief of symptoms (Laval et al 2014). If patient is to be discharged home with S/C Dexamethasone as beneficial, would consider OD dose of 6.6mg S/C or reducing dose to 3.3mg OD dependent on duration. **Please ensure a review date for Dexamethasone is documented in discharge summary and has been agreed by GP/DNs.**

N.B- Please consider time administration of first dose of Dexamethasone as can affect sleep. Additionally, steroids can be used as an appetite stimulant, therefore, prescribers please consider this when suggesting them for patients who are unable/are not eating.

5.9 Constant abdominal visceral pain- S/C Morphine 1.25-2.5mg 1-2 hrly (dependent on renal function). Then consider commencing a CSCI/24hrs (T34 syringe driver) based on previous 24hr requirements if beneficial, with PRN dose of S/C Morphine of 1/6th of dose in CSCI. **For example**, CSCI/24hrs commenced with 20mg Morphine with 2.5-5mg S/C Morphine PRN. **N.B-** Please convert any existing/regular strong opioids into CSCI/24 hrs (2:1 ratio PO to S/C. i.e. 10mg Zomorph BD totals 20mg/24 hrs which equates to 10mg S/C Morphine via CSCI/24hrs).

5.10 Intermittent abdominal pain/Spasm- Discontinue any prokinetics (Metoclopramide) or stimulant laxatives (Senna or Laxido) due to the risk of colic or bowel perforation (though this is unlikely). Colic can be described as persistent waves or intermittent spasms (due to increased endoluminal pressure) and should be monitored and documented if experienced.

Administer S/C Hyoscine Butylbromide (Buscopan) 20mg 2 hrly and then consider commencing a CSCI/24hrs (T34 syringe driver) based on previous 24hr requirements if beneficial. Hyoscine Butylbromide is an antispasmodic drug used for symptomatic relief of

gastro-intestinal wave like symptoms (colic) characterised by smooth muscle spasm. If Hyoscine Butylbromide is ineffective at increased doses ≥240mg/24hrs then consider is it the right drug? A switch to Octreotide could be an alternative- Please discuss with SPCT. Octreotide, (Sandostatin) is a synthetic version of the natural hormone Somatostatin, which is an antisecretory drug to aid reduction of nausea and vomiting due to a decreased production of gastrointestinal secretions, and therefore, may be an alternative to Hyoscine Butylbromide if required.

5.11 Nausea/Vomiting- Share decision with patient regarding consideration for NGT (wide bore Ryle's tube) insertion if frequent/ large volume vomits experienced. ***This would be for drainage only, NOT for feeding/hydration/medication.*** The NGT may help decompress the bowel, hoping to relieve distention proximal to the site of obstruction. Please monitor NGT output and record on fluid balance chart. Consider removal of the NGT if vomiting improves or is causing discomfort to the patient, or they request this.

If colic not experienced and patient is not in confirmed complete obstruction, suggest Metoclopramide 30mg via CSCI/24hrs (T34 syringe driver). Metoclopramide is a prokinetic, encouraging gut motility, therefore, in complete obstruction it is not advocated. It can be difficult to distinguish between partial or complete obstruction, so if the diagnosis is not confirmed, prokinetics can be used with caution.

If colic experienced- **STOP** Metoclopramide and commence Cyclizine 150mg via CSCI/24hrs (T34 syringe driver) with PRN S/C Haloperidol 0.5mg TDS. If no benefit with Haloperidol, suggest 2nd line S/C Levomepromazine 2.5mg-6.25 mg up to QDS/24hrs (may induce drowsiness). **In the community setting** (i.e. in patients own home), QDS administration of S/C medication is not feasible, so would therefore suggest, S/C Levomepromazine 6.25mg BD PRN 2nd line with early consideration for commencing a CSCI for symptom control measures (may induce drowsiness).

5.12 Oral Care- Please assess oral cavity at least once daily and encourage/assist with regular mouth care. If evidence of oral candida, suggest Nystatin up to 5mls QDS. Consider provision of ice poles (available from main kitchen), sucking on sugar free boiled sweets or chewing sugar free chewing gum or the use of artificial saliva products if xerostomia (dry mouth) experienced, to encourage saliva production. Advice leaflet for managing a sore mouth can be found on the trust intranet and additionally, the mouth care policy for the dying patient can also be found on the SPCT intranet page via A-Z.

5.13 Diet and hydration- Patient may eat and drink as able, though any diet or fluids are likely to return up the NGT. Therefore, please consider the consistency of any oral diet offered. Suggest soup, ice cream or texture modified diet to prevent blocking of the NGT. (***Because the NGT has not had its position formally checked, flushing the tube is NOT advocated/recommended)***. Parenteral nutrition unlikely to be appropriate, however, please discuss with nutritional team Mon-Fri via bleep 3392/3394 or review parenteral nutrition policy via intranet (for patients admitted into the acute trust). **For patients in the community setting**, please discuss with community nutritional team. Encourage regular sips of fluids as required, though acknowledge they will likely return via the NGT if inserted or induce vomiting. Supplementary fluids may be required if excessive thirst reported, S/C rather than I/V route advocated. Regular oral care may well be sufficient however to prevent xerostomia.

5.14 Constipation/ bowel management- Please monitor and record any bowel action +/- if patient is passing flatus. Avoid stimulant aperients, i.e. Senna or Laxido. A faecal softening

agent such as Sodium Docusate 200mg BD could be considered (has a slight stimulating effect at higher doses).

If stool in rectum- Suggest suppositories or an enema (e.g. Glycerin)
If rectum empty- Suggest oral laxatives as above.

Please maintain/ensure privacy and dignity of the patient, especially if patient is in a bay/ has shared toilet facilities.

5.15 Discharge planning- If the bowel obstruction does not resolve, it may still be appropriate to consider options for preferred place of care/death, incorporating an explanation to the patient and those important to them regarding FTCHC. If the plan is for home with POC/equipment, please ensure necessary AHPs have been informed/referred to. If patient has experienced good symptom benefit from NGT, would advocate discharge with NGT remaining in situ ***(for drainage only, NOT for feeding/hydration/medication)***.

5.16 If the patient is to be discharged with the NGT in situ ***(for drainage only, NOT for feeding/hydration/medication)***, a structured handover to the DNs would be required- see Appendix A&B for guidance. (Ward staff must still make an electronic referral to DN team). The patient and those important to them can also be taught C/O the NGT including, aspirating tube, spigoting tube, emptying drainage bag and disposal of drainage contents.

5.17 If the NGT requires re-insertion once discharged, e.g. If accidentally falls out, a plan for this must be discussed and clearly documented in the medical notes, in the discharge summary/LLI discharge summary and clearly highlighted on EPRO. It may also be the patient's choice that if the NGT does come out once discharged, they do not want to have it re-inserted. Symptoms would then need to be medically managed with S/C medication.

5.18 If patient lives locally to MPH, in hours (**Monday to Friday 8am-4pm**) patient can attend **ESAC** for NGT re-insertion, ***with clear communication to the hospital staff that the NGT is for drainage only as documented on EPRO/in discharge summary***. If NGT falls out overnight/over a weekend, please explain it will likely be medical management of symptoms with JIC meds. If patient lives within the West Somerset area, they can attend **Williton Hospital** (**daily, 9am-5pm**) but **MUST** telephone either site to arrange a time to attend.

There may be scope for NGT re-insertion by DNs in the patient's home (depending on where the patient lives), by St Margaret's Hospice Team or by patient attending other local community hospitals. This will be very individualised based on staff availability and staff competencies. Additionally, NGT insertion is now classed as an aerosol generated procedure, another consideration to be factored in. It is hoped more community staff will become competent in drainage/NGT insertion at home and should utilise this guidance and any other future protocol for insertion to administer safe care.

5.19 On discharge, please ensure patient (and those important to them) have the telephone numbers of both **ESAC** and **Williton Hospital** (if patient lives in West somerset) and ensure patient is aware they self-refer if required to attend for NGT re-insertion, but **MUST** call prior to arrival. **If patient has any symptoms of COVID-19, would not advocate patient attending either site solely for re-insertion of NGT.**

Consideration required for if the bowel obstruction should resolve out of hospital. Who would review this, i.e. GP and if so, have they agreed to this?

Consideration also required for if the patient experiences acute abdominal pain or begins to vomit despite NGT in situ.

Consideration additionally required for if blood appears in the NGT/drainage bag.

5.20 Suggestions for discharge- though this is not exhaustible,
Structured handover to DNs regarding C/O NGT (if that is the plan), in addition to any other ongoing care needs **i.e.** patient is being discharged for EOL care for instance.

5.21 Discharge with **x1 NGT** and **X2 drainage bags** (if NGT is remaining in situ), in case NGT requires re-insertion. Additionally, with a **week's supply of syringes** for aspiration. If NGT is remaining in situ when discharged, ensure patient and those important to them have the telephone numbers of **ESAC** and **Williton Hospital** (if that is local to them). They must **self-refer** to either site, taking in the spare NGT and drainage bag they were discharged with. **If the patient has any symptoms of COVID-19, would not advocate attending either site solely for re-insertion of NGT**

5.22 JIC meds (i.e. S/C Morphine, Midazolam, Hyoscine Butylbromide and Levomepromazine) with completed white community Palliative Care MAR chart (Please ensure minimum of 5 days' supply of JIC medications are dispensed). The patient can no longer absorb PO medication, so will require these in addition to any supply of medication for a syringe driver running at time of discharge.

5.23 Ward team to refer to St Margaret's Hospice for community support on **(01823) 333822** if patient consents to this/is not already known to them. Please ensure patient has this number also for 24/hr advice line support.

5.24 Clearly documented plan for follow up of the patient once discharged, including for instance, review/plan if the bowel obstruction resolves. Who will review this? Have they agreed to this?

5.25 Home with appropriately completed STEP form. Ensure discharge summary/ LLI discharge summary are completed, with clear documentation for patients wishes once discharged. If NGT requires re-insertion once discharged, please ensure the discharge summary and EPRO clearly state that re-insertion of NGT is for drainage purposes only as **review by DR if attending ESAC/ Williton Hospital would not be required if patient attending solely for NGT re-insertion.**

6.0 TRAINING/COMPETENCE REQUIREMENTS

6.1 It is expected that anyone administering medication or inserting NGT's will have appropriate skills, experience, and registration to do so. A training package on the insertion and care of this type of NGT is currently being developed and will be available on OWL for completion within the very near future.

6.2 People re/inserting NGT's in the community should be appropriately skilled and competent.

6.3 This guidance is intended to act as an information source for existing skills and beyond advertising with clinical teams should not need any additional training.

7.0 MONITORING/AUDIT

Element of policy for monitoring	Section	Monitoring method - Information source (e.g. audit)/ Measure / performance standard	Item Lead	Monitoring frequency / reporting frequency and route	Arrangements for responding to shortcomings and tracking delivery of planned actions
No' of patients referred to SPCT with suspected MBO	**5**	Measure through referral to SPCT	SPCT	Annually	Via CSSS governance group/SPCT meetings
No' of NGTs inserted within MPH	**5**	Measure through referral to SPCT/discharge summary	SPCT	Annually	Via CSSS governance group/SPCT meetings
No' of patients with MBO discharged out of MPH	**5**	Measure through referral to SPCT/discharge summary	SPCT	Annually	Via CSSS governance group/SPCT meetings
No' of patients discharged out of MPH with NGT in situ.	**5**	Measure through referral to SPCT/discharge summary	SPCT	Annually	Via CSSS governance group/SPCT meetings
Indication for NGT documented in discharge summary	**5**	Measure through referral to SPCT/discharge summary	SPCT	Annually	Via CSSS governance group/SPCT meetings
Supplies sent with patient on discharge (NGT/drainage bag/syringes)	**5**	Measure through referral to SPCT/discharge summary	SPCT	Annually	Via CSSS governance group/ SPCT meetings
Clear documented plan regarding re-insertion of NGT if required once discharged **OR** is the plan for the NGT to remain out?	**5**	Measure through referral to SPCT/discharge summary	SPCT	Annually	Via CSSS governance group/SPCT meetings
S/C meds for symptom control issued on discharge with white community Palliative Care MAR chart	**5**	Measure through referral to SPCT/discharge summary	SPCT	Annually	Via CSSS governance group/SPCT meetings
STEP updated as appropriate	**5**	Measure through referral to SPCT/discharge summary	SPCT	Annually	Via CSSS governance group/SPCT meetings
LLI discharge summary written	**5**	Measure through referral to SPCT/discharge summary	SPCT	Annually	Via CSSS governance group/SPCT meetings

8.0 REFERENCES

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9.0 APPENDIX A - FOR GUIDANCE ONLY

Accepting a Patient with a Nasogastric Tube for Gastric Drainage
(NOT for feeding/hydration/medication).

NGTs are used to help release pressure from gastric fluid or gas in people with a bowel obstruction. The NGT provides important symptom relief. The risks associated with use in these circumstances are much less than those for feeding, therefore people can be cared for safely in the community setting.

The tube itself will likely be a Ryle's tube, which has a wide bore and a wider end, to which a syringe, spigot or drainage bag can be attached. If the NGT is comfortable and draining and useful, it can stay in situ whilst the patient is at home for some weeks if needed.

Before the person is accepted for community care, the following needs to be discussed with the referring team and agreed:

The tube will not be used for anything other than drainage. No community team can use the NGT for administration of feed/hydration/medication for this group of patients.

- **Tube plan** - A clinical management plan is available which details;
  Any specific care related to management of the tube and equipment needed.
  What to do if the tube comes out i.e. where the patient needs to go to have it replaced and how urgent this is?
  Is a planned NGT changed needed? If so, when and who will be doing this?
  What to do if the patient has acute abdominal pain or begins to vomit despite the tube.
  What to do if blood appears in the NGT/drainage bag
  If the NGT comes out once discharged, the patient may choose not to have it re-inserted. Medical management with JIC medication would then be required.

- **Planning Ahead** - An up to date STEP form and LLI discharge summary must be available and completed fully, to ensure people get the right urgent care in the right place, if needed.

- **Working together** - What will the patient/ family/ carer be doing to manage the tube themselves? It may be possible for community nursing input be minimal and drainage of the NGT be managed solely by the patient/carers if taught/supported to do this.

9.1 APPENDIX B - FOR GUIDANCE ONLY

Dear District Nursing Team,

Patient ***** is to return home for care of their malignant bowel obstruction secondary to their cancer diagnosis. Their vomiting has much improved since the insertion of a Ryle's tube, which they have tolerated well, and they would like to continue with this at home. They are still eating and drinking but they are aware that their intake is likely minimally absorbed and most comes back up the tube into the drainage bag. They are benefitting from a reduction in the number of times they vomit in a day and their colicky abdominal pain has improved. We have not needed any extra subcutaneous fluids at this point to manage their thirst although this may be an option in the future- **(If S/C fluids are to be considered in the community, this must be discussed and agreed with the GP/DNs prior to discharge, with clear guidance of when to start/discontinue them)**. Regular oral care encouraged.

The Ryle's tube is for drainage only, NOT for feeding/hydration/medication and at present, they remain connected to a drainage bag for most of the day. Should there be any particularly difficult matter trying to pass, they are able to utilise a syringe themselves, or their partner can be involved, to aid syringing from the tube. They will be supplied with a weeks' worth of syringes and drainage bags.

Should the tube become dislodged or is felt to be unsafe or not draining, it should be reviewed during working hours. Should the tube dislodge out of hours, then this can wait until the next morning, with the major risk being vomiting for a period of time at home. This is in preference to coming into hospital late at night. The surgical team have given guidance that it should be changed only if causes discomfort or is not felt to be working well.

Should patient ***** have an increase in their abdominal pain or uncontrolled vomiting despite the tube, then they should be reviewed by their GP as to whether a re-escalation of treatment would be helpful. Overall, their goals of care are to remain at home and be as well cared for as possible. They understand that this problem is a life limiting illness on top of their incurable cancer. It is unlikely that any blood should appear in the tube, but if it does and is felt to be substantial, then this should also prompt a primary care review or out of hours GP if urgency requires. This is not in keeping with their goals of care, so re-escalation to the acute trust should be considered. Enclosed is an up to date Somerset treatment escalation plan which clarifies their not for resuscitation status and also, that they would not want to come back into hospital if at all possible, unless there was a complication of the tube that could be resolved prior to a discharge after a very short admission.

Discharging doctors are encouraged to include the following information.
Indication for NGT clearly documented in discharge summary ***(NOT for feeding/hydration/medication).***
Patient and family/carer understanding of NGT and their ability to help.
Supplies with patient on discharge for NGT care (1x NGT, 2x drainage bags and a week's supply of syringes for aspiration).
Plan for reinsertion of NGT (in-hours)- ESAC, Community hospital or? Community team. Either plan would need the team to agree that they could provide re-insertion and what the process would be for the patient.
Is a planned NGT changed needed? If so, when and who will be doing this?
Treatment escalation plan discussed, completed, and sent with patient - Yes/no.