PURPOSE & INTENT

- Enteral Nutrition (EN) is the provision of nutrients via the gastrointestinal (GI) tract, either orally or through a feeding tube. For the purpose of this manual, enteral nutrition will refer to tube feeding.

- To promote a consistent approach to support discussions regarding enteral nutrition in adults.

- To provide the health care provider teams with guidance and information when considering having a conversation regarding enteral nutrition in adults.

- Guidance for specific clinical scenarios is out of the scope of this document.

1. BACKGROUND

Decisions regarding enteral nutrition can be very difficult to make for everyone involved. These guidelines are intended to be broad, recognizing that, although enteral nutrition may be an option in many clinical scenarios, each clinical and personal situation is different.

The Clinical Practice Guidelines for starting collaborative conversations regarding Adult Enteral Nutrition were developed by an interprofessional and intersectoral regional working group to provide guidance and information to consider in facilitating discussions when enteral nutrition in adults is being considered.

2. TARGET POPULATION

Health Care Providers caring for adults for whom enteral nutrition therapy is being considered or for whom ongoing enteral nutrition is being re-evaluated.
3. PRACTICE OUTCOMES

3.1 To provide guidelines to support the practice of healthcare professionals having conversations about enteral nutrition;

3.2 To promote and facilitate discussions with, and better understanding for, the patient, family, and/or substitute decision maker (SDM) related to enteral nutrition based on comprehensive clinical assessments, current evidence, expert opinion, clinical judgment and experience;

3.3 To promote a consistent approach in discussions with patient, family, and/or SDM;

3.4 To outline and promote the efficient and appropriate use of resources, such as education materials, to assist with discussions surrounding enteral nutrition in the Winnipeg Regional Health Authority (WRHA);

3.5 To complement the use of the WRHA Adult Enteral Nutrition manual which covers procedural aspects including ordering, preparing, delivering, and monitoring of enteral nutrition if the decision is made to proceed with enteral nutrition.

(https://home.wrha.mb.ca/prog/pharmacotherapy/files/manAdultEnteralNut_May08.pdf)

4. GLOSSARY OF TERMS

4.1 Enteral Nutrition (EN)

Enteral Nutrition (EN) is the provision of nutrients via the gastrointestinal (GI) tract, either orally or through a feeding tube. When EN is provided via a feeding tube, various placement options are available. The most common types include:

Nasoenteric Route:
- A tube inserted in the nostril that goes to the stomach is called a nasogastric (NG) tube.
- A tube inserted in the nostril that goes to the small bowel is called a small bowel feeding tube.
Enterostomy Route:
- A tube that is surgically placed through the skin of the abdomen directly into the stomach is called a gastrostomy tube (GT). A percutaneous gastrostomy (PEG) tube is placed via a non-surgical procedure and is often the preferred option for most patients.
- A tube that is surgically placed through the skin of the abdomen directly into the jejunum is called a jejunostomy tube (JT). A percutaneous endoscopic gastro-jejunostomy (PEG-J) tube is placed via a non-surgical procedure and is used for the distal duodenum or jejunum placement of a feeding tube.

4.2 Patient

Patients refers to the person (patient, resident, and/or client) for whom EN is being considered.

4.3 Health Care Providers (HCP)

Health care provider (HCP) refers to all people engaged in actions whose primary intent is to enhance health, including those who promote and preserve health, those who diagnose and treat disease, health management and support providers, and professionals with specific areas of competence. The health care provided may be regulated, or non-regulated, conventional or complementary.

4.4 Substitute Decision Maker (SDM)

A Substitute Decision Maker (SDM) refers to a third party identified to participate in decision-making on behalf of a patient who lacks capacity. The task of an SDM is to faithfully represent the known preferences, or if the preferences are not known, the interest of the individual lacking capacity.

The following, in order of priority, may act as Substitute Decision Makers:
1. A proxy appointed by the individual under The Health Care Directives Act;
2. A committee appointed pursuant to The Mental Health Act if committee has the power to make health care decisions on the individual’s behalf, or a Substitute Decision Maker appointed pursuant to The Vulnerable Persons Living with a Mental Disability Act if the individual has authority to make health care decisions;
3. A parent or legal guardian of the individual, if the individual is a child;
4. A spouse, with whom the individual is cohabiting, or a common-law partner;
5. A son or a daughter;
6. If the individual is an adult, a parent of the individual;
7. A brother or a sister;
8. A person with whom the individual is known to have a close personal relationship;
9. A grandparent;
10. A grandchild;
11. An aunt or uncle; A nephew or niece

4.5 Goals of Care

The intended purposes of health care interventions and support as recognized by both a patient or substitute decision maker and the health care providers.

5. METHODOLOGY & EVIDENCE

5.1 Methodology

A literature review was conducted for existing guidelines, systematic reviews, and primary research. The following biomedical databases were searched: general biomedical databases (PubMed/Medline, CINAHL, and Scopus), clinical practice guideline-specific databases (Canadian Medical Association Infobase and Guidelines.gov – a national guidelines clearinghouse managed by the U.S. Department of Health & Human Services) and a general purpose search engine (Google.com) for English-language citations from the year 2000 to 2012. The search was limited from the year 2000, as it was believed earlier material may not be relevant due to changes over time in acceptable practice norms. Additionally the TRIP database, US National Guideline Clearinghouse, American Society for Parenteral and Enteral Nutrition (ASPEN) Documents Library, European Society for Clinical Nutrition and Metabolism (ESPEN) Guidelines on adult enteral nutrition, and Guidelines International Network (G-I-N) databases were searched for additional relevant documents. Citation management, and removal of duplicate citations, was performed in RefWorks and EndNote™ (ver. 15).

For article selection, a two-step process was used. First, one reviewer reviewed the full-text article manuscript to determine if the publication met the general inclusion criteria. A second reviewer assessed the full-text manuscript and the original reviewer’s decision. If there was disagreement on inclusion, the article was discussed in order to gain consensus.
For all included articles, relevant data was extracted into a standardized form by one reviewer and checked for completeness and validity by a second reviewer. Extracted data from all the studies were organized, refined and summarized.

5.2 Evidence

Since the majority of the recommendations in this guideline are built on expert committee opinion, the strength of the evidence for the recommendations was not graded.

6.0 DISCUSSION

6.1 Considerations for discussion:

- Overall Goals of Care need to be considered;

- EN may be recommended as an option for patients identified by screening and clinical assessments as at risk for malnutrition or malnourished, and supports their goals of care9.

- EN can only be considered as an option if the patient has a functioning gastrointestinal tract2;

- The decision to initiate EN should be based on the patient's clinical circumstances, the nature and severity of any underlying disease(s), including swallowing ability, nutritional status, oral intake, possible adverse effects, foreseeable outcomes and goals of care.11

6.2 Evidence related to specific populations:

- For patients with anorexia-cachexia syndrome of advanced terminal conditions, consideration should be given to the lack of evidence for effectiveness in such cases4;

- In individuals with advanced dementia, consideration should be given to the insufficient evidence for effectiveness in such cases12.
6.3 Discussion Time Frames

- If EN is the recommended option, a timely EN initiation is beneficial in most cases\(^8\);

- Ideally, a preempted discussion of anticipated tube feeding needs within the context of developing the patient’s plan of care is recommended. This should be done in conjunction with assessing the patient’s advance care planning/goals of care;

- Depending on the underlying condition, and if EN an appropriate option, various time frames for initiation of enteral nutrition are recommended as noted in the WRHA Enteral Nutrition Manual. ([http://home.wrha.mb.ca/prog/pharmacotherapy/files/manAdultEnteralNut_May08.pdf](http://home.wrha.mb.ca/prog/pharmacotherapy/files/manAdultEnteralNut_May08.pdf))

6.4 Role of Team Members

Discussion of enteral nutrition should be a collaborative effort involving the patient/family/SDM, the patient’s physician, and other healthcare professionals involved in the care of the patient as appropriate\(^7\). In circumstances where there is uncertainty regarding how to approach the discussion by those involved, a consult to site Spiritual Health Services, site Ethics Committees or WRHA Ethics Services may be of benefit.

- It is important that appropriate information and support for the patient/family/SDM is shared so an informed decision can be made. The format and language of the information shared should be tailored to the individual’s situation. Elements of this discussion should include consideration of:
  - clinical circumstances, including diagnosis, present medical condition, disease severity and presence of any complications\(^{10,13}\);
  - the patient’s goals of care (including previously expressed wishes), and quality of life factors (including patient’s cognitive abilities, physical needs, culture, stage of life)\(^{10,13}\);
  - therapeutic goals and available treatment options\(^7,10\);
  - risks and benefits (risk/benefit ratio) and burdens, including possible adverse effects\(^1,2,11\);
  - living with the reality of what it means not to eat, and the possible impact on social interactions, feelings of self-esteem, and emotional health;
  - limitations of the care settings;
o available alternative options and expectations if EN is not a recommended option (outcome discussions);
o responsibilities, including method and required set up if EN is a recommended option;
o sources of physical, psychological social, spiritual and financial support (such as disability benefits), where appropriate.

- When sharing information, and if EN is an appropriate recommendation, consideration should be given to whether short or long-term EN is the recommended option, and the method to be pursued (such as nasogastric or enterogastric administration), as these factors may have very different implications for the patient/family/SDM.

- HCPs involved in conversations and discussions with patient/family/SDM should be:
o aware of emotionally charged and value-laden words, such as “starvation”;  
o aware of and discuss possible patient/family/SDM concerns (e.g. sense of hunger and thirst if EN is not initiated);  
o aware that limited oral intake can be considered for non-medical reasons (e.g. comfort food).

- HCPs should be attuned to the patient/family/SDM’s own personal beliefs that can affect emotions around EN;

6.5 Factors To Consider

- Decision making process and recommendations should consider current ethical frameworks, policies, procedures and statements of local and national regulatory and professional bodies;

- In some circumstances, a time-limited trial (case dependent) of EN may be both clinically and ethically warranted provided it is in line with the patient goals of care and is accepted by all parties involved. Clear understanding of the goals of the trial, which should be specific, measureable, attainable, and realistic. The time frame for the trial should also be clearly outlined and understood. All aspects of the trial should be communicated to the patient/family/SDM and documented.

- Prior to initiation of EN clear communication regarding the nature of the intervention (short term, long term, or trial of), the stated goals (including
identification of whose goals these are) and an agreed-upon time frame for reevaluation of EN is required on a regular basis for adequacy, appropriateness and effectiveness. Ongoing discussion as the trial progresses is essential to ensure clear understanding of whether the trial goals are being met and/or anticipated to be met;

- Prior to initiation of EN, discontinuation of EN should be discussed with the patient/family/SDM. This conversation should include the end point of EN; when the stated goals of EN are not being met, and what steps are to be taken if goals are not being achieved, including the previously defined goals of care of the patient;

- In a proactive manner, recommendations and decisions made should be documented in a health care directive or advanced care planning document. Documentation should also include circumstances in which the patient/family/SDM would most definitely wish to have EN discontinued (e.g. catastrophic stroke) if initiation of EN is a recommended option;

- It is essential that there is documentation in the health record of ongoing conversations.

- If there are differences in opinion between the informed patient/family/SDM and HCPs recommendations, there are opportunities for assistance:
  - debriefings;
  - second opinions;
  - patient advocates;
  - ethics committees;
  - facility or regional resources for support
6.6 Review of Goals of Care

- The Goals of Care shall be collaboratively reviewed with the patient/family/SDM:
  - on each admission;
  - whenever there is an unanticipated significant improvement, or deterioration, in clinical status;
  - on, or shortly after, transfer to another facility;
  - upon conclusion of a time limited trial\(^1\);
  - at the request of the patient/family/SDM;
  - at the request of the Health Care Team;
  - at minimum, the Goals of Care should be reviewed annually (http://home.wrha.mb.ca/corp/policy/files/110.000.200.pdf).

- In the long term care setting, the care plan is collaboratively reviewed at a minimum of quarterly, including review of adequacy, appropriateness and effectiveness of EN;

- When it is clear that the patient’s goals of care are palliative in nature, the role of EN needs to be collaboratively re-evaluated in terms of the goals of comfort, relief of symptoms, and quality rather than quantity of life\(^1\).

7. ETHICAL CONSIDERATIONS

7.1 Patient Values in the Decision-Making Process

- The competent and informed patient is the primary decision maker with respect to treatment and care (including a decision to accept or refuse EN);

- Previously expressed goals of care as outlined in a Health Care Directive shall be followed, unless unexpected sudden change in the patient’s condition requires re-evaluation of EN;

- While there is no significant ethical or legal difference between starting or stopping an intervention (e.g. EN), some acknowledge an emotional or psychological difference between “not starting” and “stopping” an intervention\(^1\);

- An ethically sound decision to start or stop EN should be based primarily on a comprehensive clinical assessment, clinical evidence, the benefit and/or burden...
associated with EN and the health care providers’ assessment of risk associated with EN.

7.2 Substitute Decision Maker Support

- When a previously competent person becomes incapacitated and is unable to make health care decisions, HCPs must look to a validly executed Health Care Directive (i.e. instructions and/or appointment of a proxy or proxies) (http://www.wrha.mb.ca/professionals/acp/);

- Family/SDM should be given the same consideration as patients with decision-making capacity in the case that the wishes of the competent patient are not recorded\(^1\)^\(^7\).

8. SUPPORTING TOOLS AND RESOURCES


- Advance Care Planning: http://www.wrha.mb.ca/professionals/acp/


- WRHA Ethics Services: http://www.wrha.mb.ca/about/ethics/index.php


- Manitoba medical regulations: http://cpsm.mb.ca/

- Benefits and Burdens to PEG placement: http://www.compassionandsupport.org/pdfs/professionals/life_sustaining/Benefits_and_Burdens.pdf

- An Approach to Starting a Collaborative Conversation about EN Algorithm (see appendix)
9. REFERENCES


(3) CPSM (The College of Physicians & Surgeons of MB). With holding and Withdrawing Life-Sustaining Treatment Statement, http://cpsm.mb.ca/


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Appendix

Approach to Starting a Collaborative Conversation About EN

1. Adult Patient Unable to Maintain Nutrition
   - Perform comprehensive clinical assessment and attempt corrective action

2. Improvement?
   - Yes → Continue treatment as needed
   - No

3. Discussion with patient/resident, family, SDM about advance care directives, diagnosis, relevant risks, benefits of EN vs. not. Make recommendation.
   - Yes → Recommendation
   - No

4. Recommendation
   - Yes
     - Discuss components of EN and time-limited trial with specific goals.
   - No
     - Discussion of expected course of illness and functional ability

5. Incorporate in the medical record and for transmission to alternate sites of care
   - Reevaluate swallowing ability, condition, goals of care, etc.
   - Careful attention to comfort care

Guidelines are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs.