Acacium Group

Jejunostomy and Gastrostomy Care

Procedure Reference | SOP NUT 01

Version | V4.1

Procedure Name	Jejunostomy and Gastrostomy Care
Purpose of Document	To ensure that the correct preparation, procedure & outcome are achieved by implementing a consistent and systematic approach to jejunostomy care
Target Audience	All Nurses & appropriately trained care workers
Version	V4.1
Author	Karen Matthews-Shard
Date of Approval	November 2010
Published Date	November 2010
Lead Director	Karen Matthews-Shard
Review Frequency	3 yearly or when clinical or operation guidelines change
Last Reviewed	April 2024
Next Review Date	April 2027
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
V1	Dec 2016	Implementation of document history page	KNF/VM
V1.1	May 2017	Updates made to procedure for tube blockage	KNF/VM
V2	Nov 2019	3 Yearly Review	Clinical Advisory Group
V2.1	Oct 20202	Updated re rebrand	CC
V3	Nov 2022	3 Yearly review	Clinical Advisory Group
V4	Jan 2024	Rebrand	Clinical Advisory Group
V4.1	Apr 2024	Reviewed and updated	Clinical Advisory Group

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1. Introduction

People with gastrostomies and jejunostomies require ongoing care and support. This SOP provides information and procedural guidance to Acacium Group workers in order to reduce risks to the client and promote the best quality care.

2. Aim

To provide Acacium Group staff, in accordance with NICE recommendations Updated in August 2017, with information on the best practice for care in the community of children and adults who require gastrostomy and jejunostomy care.

3. Who needs to be aware of this procedure

All Acacium Group nurses and carers may care for the client that requires gastrostomy and jejunostomy care, as long as they have received appropriate training and have been assessed as competent to deliver the required standards of care.

4. Hazards/complications

Most complications are in relation to underlying disease, feeding regime, client's metabolic state and the site of entry of the tube, however below are identified the main hazards and complications.

Complication	Cause	Solution
Aspiration	Regurgitation of feed due to poor gastric emptying. Incorrect tube placement.	Medication to improve gastric emptying. Check tube placement. The only way this can be done is via litmus test. If available and as detailed in the clients care plan. Ensure Client has head at 45 degrees during feeding.
Nausea and vomiting	Related to disease/treatment. Medication such as antibiotics, chemotherapy or laxatives. Poor gastric emptying. Rapid infusion of feed.	Anti-emetics. Reduce infusion rate. Change from bolus to intermittent feeding.
Diarrhoea	Medication such as antibiotics, chemotherapy or laxatives. Radiotherapy to pelvis. Disease related.	Anti-diarrhoeal agent. If possible, GP may discontinue antibiotics, avoid microbiological contamination of feed or equipment. Treat disease or manage symptoms.

	Gut infection.	Send stool sample to check for gut infection.
Constipation	Inadequate fluid intake. Immobility. Use of opiates or other medication causing gut stasis. Bowel obstruction.	Check fluid balance and correct if necessary. Administer laxatives/bulking agents. If possible, encourage mobility. If in bowel obstruction, discontinue feed.
Abdominal distension	Poor gastric emptying. Rapid infusion of feed. Constipation or diarrhoea. Wind.	Gastric motility agents. Reduce rate of infusion. If possible, encourage mobility. Treat constipation or diarrhoea.
Blocked tube and tube leakage	Inadequate flushing or failure to flush feeding tube. Administration of medication via tube.	If a blockage is suspected or there are signs of resistance when flushing the tube, do not force water into the tube. Gently flush the tube using lukewarm water or soda water using a 50ml syringe. Use a gentle push-pull technique. Do not use acidic solutions such as fruit juices or cola as they can curdle the tube feed.
Site infection	Cross infection, reduced immunity, poor hygiene and neglect.	Follow strict infection control measures and use of PPE. Follow client specific care plan for medication and care of site.

5. Assessment of need

Assessment of care needs should be an ongoing basis and give consideration to the possible hazards/complications above, as well as considering infection, overall health and nutritional status.

6. Consent

Please read the Acacium Group Policy on consent thoroughly and ensure valid consent has been gained.

Please now ensure you understand the Consent Policy and Mental Capacity Act in full.

7. Client and relatives/care workers involvement

Initially the need for a gastrostomy or jejunostomy may be distressing to the relatives or care workers of the Client. Where possible, they should be fully consulted and informed about the care required and involved. It is important to allow family members to feel involved with the care provision and in time family members may be taught how to undertake gastrostomy and jejunostomy care for the Client, although this would not be the responsibility of the Acacium healthcare representative.

8. Client information

Detailed information should be provided on what is required to provide gastrostomy and jejunostomy care. This must be in written format to allow for reference back to the information at any time needed.

9. Discharge from hospital

After the insertion of the tube and before the Client is discharged from hospital, Acacium Group will undertake a full assessment to ensure that the Client is ready for discharge into the care of Acacium Group. A nutritional assessment should have been completed and Acacium Group given the contact details of all relevant contacts, such as a dietician or SALT team, along with information about the referrals that have been made.

10. Infection prevention and control

Reducing the risk of infection caused by bacterial contamination of enteral feeds can help reduce the incidence of morbidity and mortality in healthcare. Enteral feeding practices can pose a significant infection risk. Possible causes of contamination are listed below. A full risk assessment of the environment and competency of individuals involved should have been undertaken and documented.

Prevention of infection is therefore of vital importance for ALL Acacium Group workers caring for individuals with gastrostomies or jejunostomies. Recommendations made in this procedure aim to minimise the risk of infection caused by bacterial contamination of equipment and feeds.

Problem	Possible source
Touch contamination of equipment.	• Lack of/poor hand hygiene by staff and/or Client. • Poor non-touch technique. • Excessive manipulation of system.
Inappropriate storage of feed.	• Stored in a contaminated area. • Failure to refrigerate or temperature of fridge not appropriate if applicable. • Opened feeds kept too long. • Stored in direct sun light
Misuse of equipment.	• Prolonged use/reuse of administration sets, syringes and connectors. • Non adherence to single-use or single-service use guidelines e.g. for syringes and giving sets.
Contaminated additive.	• Medications or flush solutions

	• Addition of supplements. • Inadequate storage or management of additives.
Site problems.	• Colonisation or infection of the gastrostomy or jejunostomy site • Over granulation • Buried bumper syndrome
Cross-infection.	• Failure to adequately decontaminate hands and/or equipment between Clients (e.g. pumps). • Contaminated work surfaces. • Failure to store equipment and materials appropriately. • Failure to clean equipment.

11. Gastrostomy

A gastrostomy may be placed percutaneous endoscopically (PEG).

Possible indications for PEG placement include:

- Neurological disorder
- Head and neck cancer
- Cystic fibrosis
- Facial trauma
- Feeding is required for longer than a month

12. Procedure – care of the gastrostomy/Peg

Management of the tube site

	Action	Rationale
	First 14 days after insertion	
1.	The fixation device has been correctly measured following insertion and should not be moved for the first 14 days following insertion until the stoma tract has established, it should however be observed for tightening due to rehydration and weight gain following feeding. Consult the endoscopy unit if this occurs.	To maintain patency of tube and correct fit.
2.	Clean the skin around the gastrostomy site daily or when required with gauze and sterile water or saline. The skin fixation device should be gently lifted and the skin underneath washed and dried thoroughly.	To keep the site clean and minimise the risk of infection.
3.	A dressing is required for the first few days while there is slight bleeding; however, after this, simple gauze or mepore dressing is often sufficient. Dressings should be changed daily	To keep the site clean and minimise the risk of infection.

	after cleaning.	
4.	Gently rotate the tube through 360º on a daily basis. DO NOT ADVANCE THE TUBE UNTIL STOMA TRACT IS FORMED. **Please Note**: This is not relevant for some PEGs, carer should follow care plan.	To prevent the tube adhering to the stoma tract.
5.	Advise the Client not to have an immersion bath until the tract is formed (2-3 weeks). It is acceptable to shower but dry the site thoroughly afterwards.	To keep the area clean and minimise the risk of infection.
6.	Avoid using creams and powders.	They can damage the tube material and may cause irritation and subsequently infection.
7.	**Thereafter**	
8.	Clean with mild soap and water daily. The fixation device should be slid back to allow better access to the stoma. Ensure that the skin and fixation device are thoroughly dried.	To keep stoma site clean and minimise the risk of infection.
9.	The following should be carried out every day after cleaning: • Slide back the external fixation device/plate • Gently push the tube into the stomach by Minimum of 2-3cm and then gently pull it back to its original position so that the internal retention device is resting lightly against the stomach wall • Rotate the tube through 360º or as per manufacturer's instructions and as per care plan. There are some PEG's that should not be rotated. Please check the client's care plan for clarification. • Replace the external fixation device/plate so that it is lies 2-5mm, no more than .05cm	To prevent the internal retention device becoming fixed to the gastric wall (Buried Bumper Syndrome). This will prevent excessive movement of the tube but also ensure that the fixation device/plate is not too tight and causing pressure damage.
10.	Once the stoma has completely healed it is safe to bathe or swim. Always ensure that the end and clamps are closed and that the tube and site are dried thoroughly afterwards.	To minimise the risk of contamination.
11.	Avoid using creams and powders.	They can damage the tube material and may cause irritation and subsequently infection.
12.	Assess site for infection (redness, swelling, offensive odour etc.).	Infections may occur after 14 days e.g. if patient develops MRSA, the site should be assessed for signs & symptoms of infection as part of the procedure.

13.	A dressing is only required if there is excessive exudate or infection present. A non-occlusive dressing should be used as prescribed by the District Nurse / GP and contained within the care plan.	To prevent local contamination and contain the exudate.
14.	Flush the tube 4-6 hourly with fresh tap or cooled boiled or sterile water when the tube is not in use as per feeding regime and care plan.	To maintain patency of the tube.
15.	**Replacement of tubes**	
16.	Tubes can generally last for years (refer to manufacturer's instructions and client specific care plan). Repeated problems with stoma site infections or tube blockages may be an indication for change – consult with the Community Dietician or as per escalation plan.	To improve Client experience and improve quality of life.

13. Care of balloon gastrostomies

Balloon gastrostomy tubes (known as Mic-Key/Mini buttons) are now commonly used to replace a PEG if they are displaced or due for replacing. They are very simple to insert and replace and do not require the Client to undergo an endoscopic procedure for placement or removal. General care of a balloon gastrostomy should be carried out as for a percutaneous endoscopic gastrostomy tube as indicated in this document.

The tubes are very similar to supra-pubic catheters and are held in place with a balloon on the inside of the stomach and a flange on the outside. They usually last between 3-6 months (depending on manufacturer's instructions) and then need to be replaced with a spare balloon gastrostomy tube. As the balloon is sitting in the acid environment of the stomach it is vital that it is checked every 7-10 days

To maintain the placement of the balloon, regular deflation and inflation of the balloon needs to be carried out as per the clients care plan. This is done to check the fluid level in the balloon and to determine if there has been any fluid loss and if it is at the level recommended by the manufacturer.

Clients, relatives and care workers may be instructed how to regularly deflate and inflate the tube and replace it every 3-6 months. If the Client, relatives or care workers are unable to do this, an appropriately trained Acacium Group worker will do this for the Client if part of their Commissioned care.

Fluid loss may cause the balloon gastrostomy to become displaced and fall out. It is recommended to check the volume every 7 to 10 days to validate balloon integrity. Regular checking helps to prevent the tubes falling out and the need for emergency replacements.

If the tube becomes perished and loses fluid it will not remain in-situ and must be replaced. If the tube falls out it must be replaced within 4 hours otherwise the stoma tract will close up. The Client will be provided with a replacement tube of the correct size to keep at home as a spare tube, so that replacement can be undertaken. Size specific details should be within the care plan.

Most care provided is the same as for as a PEG, please see below for how to check the volume of water in the balloon on a weekly basis:

	Action	Rationale
1.	Pre-fill a new syringe with the recommended volume of sterile water, as stated on the balloon inflation valve. Use Gloves and apron and wash your hands.	To be prepared to inflate the balloon with a new amount of water if some water has been lost from the balloon holding the tube in position.
2.	Use a second syringe to withdraw the water already in the balloon. Care should be taken to ensure that the tube remains in place until the balloon is re-inflated (the tube can be taped to the skin to secure it if wished). Check the volume of fluid obtained – it should be no more than 10% different than the volume recommended by the manufacturer (e.g. 4.5-5.5ml for a 5ml balloon).	To check that there is enough water in the balloon to maintain the tube in position.
3.	If the volume obtained was satisfactory then re-inflate the balloon using a new syringe and fresh sterile water. If the volume obtained is more than 10% less (or more) than expected then re-inflate the balloon with fresh sterile water but do not use until the tube is checked and secured.	To ensure tube is correctly placed and will not fall out.
	Replacement	
4.	Most tube manufacturers recommend replacement every 10-14 weeks. Fresenius G tube has a longer life-span of 9 months and the balloon volume only needs to be checked every 6 weeks. Or as indicted by consultant.	To ensure correct process for tube replacement.
5.	Syringes, enteral syringes / consumables to be changed according to client specific care plan.	To reduce the risk of infection and follow specific guidelines.

14. Replacing a balloon gastrostomy

Equipment

- New gastrostomy tube
- pH paper
- Gauze
- 50ml syringe
- Lubricating jelly
- Inflation fluid
- 2 x 5ml or 10ml syringes
- Cooled boiled water for flushing
- Disposable gloves
- Disposable Apron

Methods

This should only be undertaken if this is commissioned and performed by competent and adequately trained staff.

	Action	Rationale
1.	Wash and dry hands thoroughly. Assemble the necessary equipment. Check the packaging of the tube and syringes that they are the correct size and within the expiry date.	To ensure tube and equipment to be used is within shelf life.
2.	Explain the procedure. Lay the patient flat.	To obtain valid consent and gain user support. To prepare the Client for the procedure.
3.	Check the new balloon gastrostomy tube by inserting the manufacturers recommended volume of sterile water into the inflation valve. Once you are happy the balloon is patent, deflate the balloon and keep fluid in syringe. Slide the external retention device away from the balloon.	To ensure the balloon inflates symmetrically and there are no leaks.
4.	If the old tube is still in place, use a new syringe to deflate the balloon by gently drawing back on the plunger until no more fluid comes out of the balloon.	To ensure the old tube is fully ready for deflation and removal.
5.	Place a gauze swab under the old tube and gently remove it. Do not be alarmed if there is a small amount of blood as this can sometimes happen. Clean the skin around the stoma and dry thoroughly.	To catch any secretions when removing the tube, aiming to keep the skin clean.
7.	Lubricate the end of the new tube with a small amount of lubricating jelly and insert the tube into the stoma. Gently rotating the tube as you insert it can also help.	To ease insertion of the new tube.
8.	Using a 50ml syringe, test the position of the tube by aspirating gastric fluid and testing with pH paper. A value of 5.5 or less confirms gastric placement. If the PH value is outside of agreed parameters, prior to any commencement of feed, it should be escalated as per the care plan.	To ensure the tube is placed in the correct place.
9.	Inflate the balloon with the correct volume of fluid from the pre-filled syringe then gently pull the gastrostomy tube back until there is light resistance from the balloon touching the stomach wall.	To ensure the tube is positioned correctly.
10.	Wipe the skin and tube to remove excess lubricating jelly and then slide the external retention device so that it lies at least 2-3mm from the skin surface.	To correctly position the external retention device.
11.	Flush the tube with at least 30ml cooled boiled or sterile water.	To maintain patency of the tube.

12.	Wash your hands and ensure that a replacement balloon gastrostomy tube is available or ordered.	To minimise the risk of transmitting infection and to be ready for when the next tube needs inserting.

15. Jejunostomy

A jejunostomy is preferable to a gastrostomy if a Client has undergone upper gastrointestinal surgery or has severe delayed gastric emptying (Thomas & Bishop 2007).

16. Management of the jejunostomy tube

Much guidance is the same as for the gastrostomy e.g. not using powders or creams, when to swim or take baths. Below are specific issues related to general care that is not reflected in the gastrostomy section.

	Action	Rationale
	First 14 days after insertion	
1.	All care in the first 14 days is the same as for gastrostomy BUT **these tubes should NOT be rotated or pushed**. if there is any concern about the position of the tube, the escalation process should be followed as per the clients care plan.	Rotating or pushing the tube will cause trauma to the intestinal wall.
	Thereafter	
2.	**These tubes should NOT be rotated or pushed.**	Rotating or pushing the tube will cause trauma to the intestinal wall.
3.	If the sutures become loose, they **MUST** be replaced **IMMEDIATELY** and the escalation process followed.	Loose sutures cause a risk of displacement of the jejunostomy.
4.	If there are any concerns that the tube has displaced then **DO NOT USE** until correct position has been confirmed.	Use of the tube when it is displaced is dangerous to the client.
5.	The clients care plan should be specific to the type of jejunostomy being used and should detail any specific care requirements. For example, one type of jejunostomy (Vygon MIC®) only requires sutures for first 7-10 days, then kept in place with subcutaneous dacron cuff – seek advice from feed company nurse or community dietitian if unsure whether sutures required.	Ensure tube is securely fixed according to manufacturer's instructions.
	Replacement	
6.	Replacement should be completed in hospital.	To ensure safe reinsertion.
7.	The lifespan of these tubes will vary depending on the type of tube inserted and all details and references to manufacturers specific requirements should be included within the clients care plan.	

17. Enteral feeding

Equipment supply and use

Pump

On discharge to the community, the Client will be issued with a pump for use at home if required, usually loaned by the feeding company. The pump should be cleaned with a wet cloth and detergent and/or a detergent wipe then dried on a regular basis. If any feed is spilt on the pump it should be cleaned immediately to prevent bacterial contamination.

Pumps require annual servicing. Servicing is done by the feeding company who will take the old pump and replace with a new one. If there are any problems with the pump, the carer or whoever is responsible should contact appropriate person/contact as per the care pan and assessment. Pumps are usually replaced within 24 hours; however if there are any concerns the client should be transferred to a place of safety if appropriate as per Contingency and escalation plan. The contact number for servicing and out of hours support should be in the care plan and on the pump.

Giving sets/containers

Non-sterile syringes are used for flushing or medication administration, they can be used for 7 days or as single use, they must be discarded as detailed within the care plan. If damaged prior to renewal dates they must be discarded. During the seven days, after EACH use the syringe must be cleaned thoroughly in hot soapy water using a brush or clean washing-up cloth. Syringes must be visibly checked for cleanliness and rinsed with fresh tap water or cooled boiled water. Avoid using cleaning cloths which can quickly become contaminated. Alternatively, freshly opened, sterile water can be used. They must then be left to air dry, with the plunger pulled out, on a clean surface or in a clean plastic box. They are for single patient use only.

If an enteral syringe is used to administer feed then it must be treated in the same way as a giving set and used for 24 hours only (in infants the giving set and container should be changed after every feed). Between uses it must still be washed thoroughly in warm soapy water using a brush or clean washing-up cloth, rinsed and air-dried and kept on a clean surface or in a clean plastic box.

Water

Following an environmental risk assessment of the client's living conditions, water should be boiled and then cooled before use in enteral feeding (**bar feeding into the jejunum and infants which both require sterile water).** Or as detailed within their specific care plan or dietician plan.

Supply of feed

Enteral feeds are obtained on prescription via the patient's GP under the direction of the hospital/community dietician. There are two ways which feed can be supplied to patients on enteral feeds:

Directly from the Home Enteral Feeding Company

Prescriptions can be sent directly to the feed company by either the Client themselves or the GP on a monthly basis. The feed company will supply the pre-paid envelopes. The feed will then be delivered directly to the Client's home on a monthly basis with all the feeding equipment.

- Via the Community Pharmacy
  Many Clients still like to take their prescription to their local pharmacy. If this is the case, on a monthly basis, the prescription should be taken to the pharmacist and they will order in the required feed. Ideally the pharmacist would be able to deliver the feed directly to the Client's home as it often involves several boxes and is extremely heavy.

The client is responsible for ensuring all supplies are readily available.

Administration of feeds

- Equipment
- Pump
- 50ml enteral syringe or catheter tipped syringe
- Labelled feed
- Administration set
- Alcohol wipe if using feed in a glass container
- Gloves and gowns

	Action	Rationale
1.	Explain the procedure.	In order to gain valid consent and their involvement with their care.
2.	Ensure Client is at a minimum of 45 degrees angle (a minimum of 3 pillows) or sitting out in a chair to achieve the correct position for feeding, wherever possible and as detailed within the clients care plan This should be done whilst feeding and for at least 1-2 hours after the feeding has stopped.	This is to prevent reflux and aspiration of feed. This is particularly important for overnight feeding.
3.	Wash hands thoroughly or use alcohol hand gel to disinfect hands.	To minimise the risk of infection.
4.	Assemble all equipment, using a cleaned work surface.	To prepare for efficient set up of feed in a clean environment.
5.	Check use by date on feed, check the feed is correct according to the enteral feeding regimen/prescription, check condition of the feed and shake lightly. If the feed is past its use by date or has separated or looks suspicious discard it and always use a new feed pack/bottle. If using a glass bottle with crown cap top wipe both bottle opener and crown cap with an alcohol wipe before opening.	To ensure that feed is not contaminated when used. Shake feed gently as air bubbles will cause blockages in giving sets. To minimise infection when inserting giving set.
6.	Put on non-sterile gloves.	
7.	Open the feed administration system and put all equipment on the prepared work surface using a non-touch technique.	To minimise the risk of contamination and infection to the client.
8.	The tube should be flushed with water before and after feeding as per client specific regime / care plan. If the patient has a higher risk of infection i.e. immuno-compromised, or fed via a jejunostomy**,** use sterile water.	This is vital to stop the tube blocking. To reduce the risk of the Client developing an infection.

9.	Administer any medications and flush tube as directed in the medication administration guidelines and as per the clients care plan (see Gastrostomy and Jejunostomy SOP MED 15).	To minimise interference with feed. Can only be done if medications are due.
10.	Set up feed following manufacturers pump instructions and feeding regimen at the rate of administration indicated.	Commence feed.
	Pump feeding	
11.	Using a non-touch technique hang feed bottle/pack or pour the full amount of feed into the feed container/reservoir.	Ready to commence feed.
12.	Release clamp to allow feed to run through administration set until tube is full. Secure the clamp. Ensure no air is present within the tubing.	Prepare for allowing the free flow of feed.
13.	Check pump is at correct settings/feeding rate and is plugged in or has enough battery life. Connect the administration set to the pump. Check height of feed reservoir in relation to the pump (see manufacturer's instructions).	To ensure feed is not administered too quickly and allow flow with the correct amount of gravity.
14.	Securely attach the administration tube to the gastrostomy or jejunostomy tube ensuring privacy and dignity is maintained.	To commence the feed with the tube securely attached to the giving set.
15.	Release clamp on tube. Commence feed at the rate prescribed.	Commence feed.
16.	Maintain regular checks on flow, content of reservoir and connections for leakage. Observe the Client for signs of distress or discomfort. Ensure the pump is plugged in or has enough battery life.	To ensure smooth running of the procedure and maintenance of expected health.
17.	On completion of feed: • If gloves are contaminated remove and wash hands thoroughly. Put on new disposable gloves • Apply clamps • Disconnect administration set • Using 50ml non-sterile syringe (Baxa enteral catheter tip syringe) to flush tube with water. Volume according to feeding regimen • Disconnect extension set if used • Close feeding tube securely • Discard equipment in the appropriate bin • Remove gloves and wash hands and dry thoroughly.	To complete the feed process.
18.	Check the individual's comfort and dignity e.g.	Continue Client's daily activities.

	clothes tucked in, then escort them to continue their day's activities.	
19.	Clear away used equipment. Wash enteral syringe and extension set if used, allow to air dry. Discard feed container and administration set. Document in progress notes.	

18. Oral care

Oral care is likely to be required. Please follow SOP for mouth care.

19. Associated Policies / SOPs

Policies

CLIN 03 Medicines Management Policy
CLIN 06 Consent Policy

SOPs

SOP GEN 14 Mouth Care
SOP NUT 02 Enteral Feeding
SOP NUT 03 Gastrostomy and Jejunostomy Feeding
SOP NUT 04 Naso-Gastric Tube Feeding Adults and Children

20. References

- The Royal Marsden Hospital Manual of Clinical Nursing Procedures; ninth edition; Dougherty L, Lister S; 2008, Wiley-Blackwell
- NHS Wandsworth 2009; Community enteral feeding guidelines
- Nursing Times – PEG tubes; dealing with complications 31.10.2014

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

pulse Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group