Nasogastric tube support

Hospital-in-the-Home (HITH) can provide education and support for families transitioning to home with a nasogastric tube (NGT) for feeding/medication administration. As with any other HITH admission, this requires a safe home environment and consent from caregivers.

HITH (Wallaby) admission criteria and protocol

Wallaby not appropriate

- No parent/main caregiver trained in NGT cares or feed administration

→ Remain in hospital

Wallaby possible

- Short term NGT use
- Not gaining weight on current regimen
- Lives > 60km from RCH
- International patients: will not have HEN support and will have to pay for all supplies

→ Contact HITH fellow on 52784, or HITH AUM on 52598

Wallaby appropriate

- At least one parent/caregiver competent in care of NGT care (including pump if needed)
- If long term NG: Enrolled in HEN program, accepted by a Gen Med/Neonatal team for follow up
- Gaining weight on current regimen

→ Contact HITH AUM on 52598. Complete EMR HITH referral

Prior to family leaving hospital:

- HITH CNC/AUM will review patient & family, along with HITH dietician/speech pathologist
- Written feeding plan given to family by home team (& documented in EMR)
- Plan for weight monitoring documented, including thresholds for escalation to home team
- Family have NGT equipment/supplies required
- HITH order set on EPIC completed:
    - EMR referral to HITH
    - EMR 'Transfer Order Reconciliation' completed
- Clear documentation of follow up plan, & appropriate referrals in place (NOTE: to be accepted on HEN program, needs to be seen by a general paediatrician/neonatologist at least annually)
- NOTE: HEN program to provide supplies/consumables for long-term NG patients

HITH protocol – nursing and medical

Home team medical responsibilities

Clear feeding and weight monitoring plan written in EMR and provided to family
Update Wallaby team (on 54770) re plan changes post outpatient reviews
Overall medical responsibility for patient

HITH medical team responsibilities

Identify patients that would benefit from Wallaby MDT involvement
Providing clinical leadership to the Wallaby MDT team for patients of complexity
Bi-weekly case conference to review patient progress

Wallaby care requirements

Daily visit for education & hydration assessment
Weight monitoring as per home team recommendation
Allied health input (dietitian/ speech therapy/ physiotherapy/ social worker/ occupational therapy/ infant mental health) as required

Red flags for escalation

Concern for caregiver's mental health, ability to cope - discuss within Wallaby MDT and liaise with home team. Consider Mother Baby Unit referral.
Child identified at risk – discuss with Wallaby MDT/ home team and consider DHHS report

Other potential issues

Not tolerating feeding plan or failure to gain adequate weight –Wallaby MDT liaise with home team

Readmission

Dehydration requiring bolus fluids/ replacement of deficit
Weight loss/ static weight despite intervention

If requires transfer back to hospital, home team will liaise with the bed manager.

Discharge plan

Discharge once family competent with cares, weight stable/gain, or NGT removed
Follow up booked with either MCHN, GP or RCH Post Acute Care program