Nutrition Administration
1. Open the cap to an access port of the MIC* PEG Tube and unclamp the tube.
2. Use an ENFit™ syringe to flush the tube with the prescribed amount of water as described in the General Flushing Guidelines.
3. Remove the flushing syringe from the access port.
4. Securely connect an ENFit™ feed set or an ENFit™ syringe to the access port.
   ▲ Caution: Do not over-tighten the feed set connector or the syringe to the port.
5. Complete feeding per the clinician’s instructions.
6. Remove the feed set or syringe from the access port.
7. Use an ENFit™ syringe to flush the tube with the prescribed amount of water as described in the General Flushing Guidelines.
8. Remove the flushing syringe from the access port.
9. Close the cap to the access port.

Medication Administration
Use liquid medication when possible and consult the pharmacist to determine if it is safe to crush solid medication and mix with water. If safe, pulverize the solid medication into a fine powder form and disperse the powder in warm water before administering through the feeding tube. Never crush enteric coated medication or mix medication with formula.
1. Open the cap to an access port of the MIC* PEG Tube and unclamp the tube.
2. Use an ENFit™ syringe to flush the tube with the prescribed amount of water as described in the General Flushing Guidelines.
3. Remove the flushing syringe from the access port.
4. Securely connect an ENFit™ syringe containing the medication to the access port.
   ▲ Caution: Do not over-tighten the syringe to the access port.
5. Deliver the medication by depressing the ENFit™ syringe plunger.
6. Remove the syringe from the access port.
7. Use an ENFit™ syringe to flush the tube with the prescribed amount of water as described in the General Flushing Guidelines.
8. Remove the flushing syringe from the access port.
9. Close the cap to the access port.

Gastric Decompression
Gastric decompression may be performed via either gravity drainage or low intermittent suction.
1. Open the cap to the access port of the MIC* PEG Tube and unclamp the tube.
2. For gravity drainage, place the opened access port of the MIC* PEG Tube directly over the opening of an appropriate container.
   ▲ Note: Ensure the open access port is positioned below the stoma.
3. For low intermittent suction, connect an ENFit™ syringe to the access port.
4. Apply low intermittent suction by slowly retracting the plunger of the syringe in short intervals.
   ▲ Caution: Do not use continuous or high pressure suction. High pressure could collapse the tube or injure the stomach tissue and cause bleeding.
5. Disconnect the decompression syringe from the access port.
6. Use an ENFit™ syringe to flush the tube with the prescribed amount of water as described in the General Flushing Guidelines.
7. Remove the flushing syringe from the access port.
8. Close the cap to the access port.

Daily Care & Maintenance Check List
Assess the patient
Assess the patient for any signs of pain, pressure or discomfort.

Assess the stoma site
Assess the patient for any signs of infection, such as redness, irritation, edema, swelling, tenderness, warmth, rash, purulent, or gastrointestinal drainage. Access the patient for any signs of pressure necrosis, skin breakdown, or hypergranulation tissue.

Clean the stoma site
Use warm water and mild soap.
Use a circular motion moving from the tube outwards. Clean sutures, external bolsters and any stabilizing devices using a cotton-tipped applicator. Rinse thoroughly and dry well.

Clean the tube
Assess the tube for any abnormalities such as damage, clogging, or abnormal dislodgment.

Clean the feeding tube
Use warm water and mild soap being careful not to pull or manipulate the tube excessively. Rinse thoroughly and dry well.

Clean the gastric ports
Use a cotton tip applicator or soft cloth to remove all residual formula and medication.

Rotate the tube
Verify that the external bolster rests 1–2 mm above the skin.

Flush the feeding tube
Flush the feeding tube as described in the General Flushing Guidelines section above.

Tube Occlusion
Tube occlusion is generally caused by:
- Poor flushing techniques
- Failure to flush after measurement of gastric residuals
- Inappropriate administration of medication
- Pill fragments
- Thick formulas, such as concentrated, blended, or enriched formulas that are generally thicker and may contain particulates
- Formula contamination that leads to coagulation
- Reflux of gastric or intestinal contents up the tube

To Unclog a Tube
1. Make sure that the feeding tube is not kinked or clamped off.
2. If the clog is visible above the skin surface, gently massage or milk the tube between fingers to break up the clog.
3. Connect an ENFit™ syringe filled with warm water into the appropriate access port of the tube and gently pull back on then depress the plunger to dislodge the clog.
4. If the clog remains, repeat step #3. Gentle suction alternating with syringe pressure will relieve most obstructions.
5. If this fails, consult with the physician. Do not use cranberry juice, cola drinks, meat tenderizer or chymotrypsin, as they can actually cause clogs or create adverse reactions in some patients. If the clog is stubborn and cannot be removed, the tube will have to be replaced.

Warning: For enteral nutrition and/or medication only.
For more information, please call 1-844-425-9273 in the United States, or visit our website at halyardhealth.com.

Educational Booklets: “A Guide to Proper Care” and “A Stoma Site and Enteral Feeding Tube Troubleshooting Guide” is available upon request. Please contact your local representative or contact Customer Care.
HALYARD® MIC® Percutaneous Endoscopic Gastrostomy (PEG) Kit
with ENFit™ Connectors
PULL Technique

Re: Only: Federal Law (USA) restricts this device to sale by or on the order of a physician.

Description
The HALYARD® family of MIC® gastrostomy feeding tubes allows for delivery of enteral nutrition and medication directly into the stomach and/or gastric decompression.

Indications for Use
Gastrostomy tube feeding may be indicated for patients needing long-term enteral support or hydration secondary to a primary condition relating to the head and/or neck. These conditions include stroke; cancer; head and neck tumors, injuries, or trauma; and neurological disorders resulting in a chewing or swallowing abnormality. This device (sold in a kit) is intended as an initial placement device. The device is placed by one of two techniques, the PULL technique and the over-the-wire guidewire technique (PUSH technique). This guidance covers the PULL technique.

Contraindications
Contraindications for placement of a gastrostomy feeding tube include, but are not limited to: colonic interposition, partial herniation, perforation, morbid obesity and esophageal stenosis.

Warnings
Do not reuse, reprocess, or resterilize this medical device. Reuse, reprocessing, or resterilization may 1) adversely affect the known biocompatibility characteristics of the device, 2) compromise the structural integrity of the device, 3) lead to the device not performing as intended, or 4) create a risk of contamination and cause the transmission of infectious diseases resulting in patient injury, illness, or death.

After MIC® PEG Tube placement, proper positioning of the internal bumper against the gastric mucosa must be verified endoscopically. Tension on the MIC® PEG Tube should be avoided to minimize the risk of complications.

Failure to comply with these warnings may result in pressure necrosis of the gastric mucosa with subsequent erosion, perforation, and/or leakage of gastric contents into the peritoneum. Migration of the internal bumper into the stoma tract or embedding into the stomach wall may also occur over time.

Dispose of all sharps according to facility protocol.

Complications
The following complications may be associated with any gastrostomy feeding tube:
- Skin Breakdown
- Infection
- Hypergranulation Tissue
- Stomach Ulcers
- Intraparenoidal Leakage
- Pressure Necrosis

Note: Verify package integrity. Do not use if package is damaged or sterile barrier compromised.

PULL Placement Procedure
1. Use a clinically approved method to prepare and sedate the patient for an endoscopic procedure.
2. Use a clinically approved procedure to perform the gastroscopy.
3. With the patient in a supine position, infuse the stomach with air and transfuse the abdominal wall.

Caution: Proper selection of the insertion site is critical to the success of this procedure. Select gastrostomy tube site. This site (typically the upper left quadrant) should be free of major vessels, viscera, and scar tissue.
4. Depress the intended insertion site with a finger. The endoscopist should clearly see the resulting depression on the anterior surface of the gastric mucosa.
5. Prop and drape the skin at the selected insertion site. Locally anesthetize the insertion site.
6. Follow local anesthetic, make a 1 cm (approximate) incision through the skin with the scalpel.
7. Insert the introducer needle system through the incision, advancing through the peritoneum and the stomach wall.

Fig. 1

8. When the needle is observed in the stomach, remove the introducer needle from the introducer cannula by firmly holding the cannula hub and pulling back on the needle hub.
9. Insert the retrieval snare into the endoscope, and push the retrieval snare through endoscope until observed in the stomach.
10. Place the looped placement wire through the introducer cannula into the stomach. Grasp the looped placement wire with a retrieval snare. Withdraw the retrieval snare into the endoscope channel. Fig. 2
11. Remove the esophagus and the looped placement wire through the oropharynx. Pull approximately 5 inches (13 cm) of the looped placement wire from the mouth.

12. Slowly and smoothly feed the looped placement wire into the introducer cannula as the endoscope is retracted. Keep the introducer cannula in place in the stomach with the distal end of the placement loop outside the abdomen. Fig. 3
13. Connect the looped placement wire with the tube loop. Fig. 4
14. Lubricate the MIC® PEG Tube with a water-soluble lubricant. Apply traction to pull the placement loop and the tube back through the oropharynx, esophagus, and into the stomach. Fig. 5
15. Re-enter the oropharynx with the endoscope and visually follow the gastrostomy tube as it enters the stomach. Slide the introducer cannula out of the incision site and gently pull the PEG dilator tip through the abdominal wall.
16. Use a rotating motion to slowly work the tube up and out until the internal bumper is just against the gastric mucosa.

Note: Graduated markings on the body of the tube will assist in determining the progress of the tube as it exits the abdomen.

Caution: Do not use excessive force to pull the tube into place. This could harm the patient and damage the tube.
17. Cleanse the tube and stoma site and apply a sterile gauze dressing. Cut the tube loop wire with scissors and discard the tube loop and placement wire.
18. Slide the external bumper over the proximal end of the MIC® PEG Tube and push the external bumper into place next to the sterile gauze dressing. Visually verify that the internal bumper is properly placed. Remove the endoscope. The external bumper should be positioned approximately 2 mm above the skin.

Caution: Do not apply excessive tension. There should be no compression of the gastric mucosa or the skin. Optionally, a suture loop (not supplied) may be tied around the external bumper to minimise movement of the MIC® PEG Tube while the stoma is healing.
19. Cut the MIC® PEG Tube straight across, leaving an appropriate length to attach a MIC® Feedhead Adapter. Discard the removed portion of the tube.
20. Slide the clamp on the MIC® PEG Tube.
21. Insert the barb connector of the MIC® Feedhead Adapter completely into the proximal end of the MIC® PEG Tube.

Skin and Stoma Care
1. Keep the skin around the MIC® PEG Tube stoma site clean, dry, and free of drainage.
2. After the stoma is healed, a dressing is not necessary with the MIC® PEG Tube and may even cause moisture retentive in skin irritation.

Removal of the MIC® PEG Tube
The MIC® PEG Tube should be removed by either traction removal through the stoma or through endoscopic retrieval.

Caution: It is not recommended that a portion of the tube be cut to allow the internal bumper to pass.

Caution: When the 14 Fr PEG is used, use endoscopic removal method only.

Warning: Never attempt to change the tube unless trained by the physician or other health care provider.

Traction Removal of the MIC® PEG Tube
1. When the physician determines that the tract is formed (usually within 4–6 weeks after placement of PEG), the MIC® PEG Tube may be replaced with an alternative feeding device. We recommend using one of the following:
- MIC® Key™ Low-Pressure Gastrostomy Tube
- MIC® Gastrostomy Tube
2. To remove the tube, prop the patient for MIC® PEG Tube endoscopic removal using standard procedure.
3. Cut the MIC® PEG Tube at skin level.
4. Retrieve the MIC® PEG Tube using endoscopic tools according to facility protocol.
5. Replace the MIC® PEG Tube with the appropriately sized gastrostomy tube.

Feedhead Adapter with ENFit™ Connectors Replacement Procedure
1. Cleanse the skin around the stoma site and allow the area to air dry.
2. Clamp the tube and trim the MIC® PEG Tube as necessary using scissors. Cut the tube straight across.
3. Push the Replacement Feedhead Adapter with ENFit™ Connectors completely into the MIC® PEG Tube.
4. Unclamp the replacement use.

Tube Patency Guidelines
Proper tubing flushing is the best way to avoid clogging and maintain tube patency. The following are guidelines to avoid clogging and maintain tube patency:

- Flush the feeding tube with water every 4–6 hours during continuous feeding, anytime the feeding is interrupted, before and after every intermittent feeding, or at least every 8 hours if the tube is not being used.
- Flush the feeding tube after checking gastric patency.
- Flush the feeding tube before and after medication administration and between medications. This will prevent the medication from interacting with formula and potentially causing the tube to clog.
- Use liquid medication whenever possible and consult the pharmacist to determine if it is safe to crush solid medication and to mix with water. If safe, pulverize the solid medication into a fine powder form and disperse the powder in warm water before administering through the feeding tube.

Never crush enteric-coated medication or mix medication with formula. Avoid using acidic flushes such as cranberry juice and cola beverages to flush feeding tubes as the acidic quality when combined with formula proteins may actually contribute to tube clogging.

General Flushing Guidelines
Flush the feeding tube with water using an ENFit™ syringe every 4–6 hours during continuous feeding, any time the feeding is interrupted, or at least every 8 hours if the tube is not being used. Flush the feeding tube after checking gastric residuals. Flush the feeding tube before and after medication administration. Avoid using acidic irrigants such as cranberry juice and cola beverages to flush feeding tubes.

- Unclamp the MIC® PEG Tube before flushing.
- Use a 30 to 60 ml ENFit™ syringe. Do not use smaller size syringes as this can increase pressure on the tube and potentially rupture smaller tubes.
- Ensure the second access port (if applicable) is closed with the tethered cap prior to flushing.
- Use room temperature water for tube flushing. Sterile water may be appropriate where the quality of municipal water is of concern. The amount of water will depend on the patient’s needs, clinical condition, and type of tube, but the average volume ranges from 10 to 50 ml for adults, and 3 to 10 ml for infants. Hydration status also influences the volume used for flushing feeding tubes. In many cases, increasing the flushing volume can avoid the need for supplemental intravenous fluid. However, individuals with renal failure and other fluid restrictions should receive the minimum flushing volume necessary to maintain tube patency.
- Do not use excessive force to flush the tube. Excessive force can perforate the tube and can cause injury to the gastrointestinal tract.
- Document the time and amount of water used in the patient’s record. This will enable all caregivers to monitor the patient’s needs more accurately.

Never crush enteric-coated medication or mix medication with formula. Avoid using acidic flushes such as cranberry juice and cola beverages to flush feeding tubes.
HALYARD® MIC® Percutaneous Endoscopic Gastrostomy (PEG) Kit with ENFit™ Connectors
PULL Technique

Re: Only: Federal Law (USA) restricts this device to sale by or on the order of a physician.

Description
The HALYARD® family of MIC® gastrostomy feeding tubes allows for delivery of enteral nutrition and medication directly into the stomach and/or gastric decompression.

Indications for Use
Gastrostomy tube feeding may be indicated for patients needing long-term enteral support or hydration secondary to a primary condition relating to the head and/or neck. These conditions include stroke; cancer; head and neck tumors, injuries, or trauma; and neurological disorders resulting in a chewing or swallowing abnormality. This device (sold in a kit) is intended as an initial placement device. The device is placed by one of two techniques, the PULL technique and the over-the-guidewire technique (PUSH technique). This guidance covers the PULL technique.

Contraindications
Contraindications for placement of a gastrostomy feeding tube include, but are not limited to coloc interposition, portal hypertension, peritonitis, morbid obesity and esophageal stenosis.

Warnings
Do not reuse, reprocess, or resterilize this medical device. Reuse, reprocessing, or resterilization may 1) adversely affect the known biocompatibility characteristics of the device, 2) compromise the structural integrity of the device, 3) lead to the device not performing as intended, or 4) create a risk of contamination and cause the transmission of infectious diseases resulting in patient injury, illness, or death.

After MIC® PEG Tube placement, proper positioning of the internal bumper against the gastric mucosa must be verified endoscopically. Tension on the MIC* PEG Tube should be avoided to minimize the risk of complications.

Failure to comply with these warnings may result in pressure necrosis of the gastric mucosa with subsequent erosion, perforation, and/or leakage of gastric contents into the peritoneum. Migration of the internal bumper into the stoma tract or embedding into the stomach wall may also occur over time. Dispose of all sharps according to facility protocol.

Complications
The following complications may be associated with any gastrostomy feeding tube:
- Skin Breakdown
- Infection
- Hypergranulation Tissue
- Stoma Ulcers
- Intraperitoneal Leakage
- Pressure Necrosis

Note: Verify package integrity. Do not use if package is damaged or sterile barrier compromised.

PULL Placement Procedure
1. Use a clinically approved method to prep and sedate the patient for an endoscopic procedure.
2. Use a clinically approved procedure to perform the gastroscopy.
3. With the patient in a supine position, infiltrate the stomach with air and transilluminlate the abdominal wall.

Caution: Proper selection of the insertion site is critical to the success of this procedure.

4. Select gastrostomy site. This site (typically the upper left quadrant) should be free of major vessels, viscera, and scar tissue.
5. Depress the intended insertion site with a finger. The endoscope should clearly see the resulting depression on the anterior surface of the gastric wall.
6. Prep and drape the skin at the selected insertion site. Locally anesthetize the insertion site.
7. Following local anesthesia, make a 1 cm (approximate) incision through the skin with the scalpel.
8. Insert the introducer needle system through the incision, advancing through the peritoneum and the stomach wall.

Fig. 1
9. When the introducer is observed in the stomach, remove the introducer needle from the introducer cannula by firmly holding the cannula hub and pulling back on the needle hub.
10. Insert the retrieval snare into the endoscope, and push the retrieval snare through endoscope until observed in the stomach.
11. Place the looped placement wire through the introducer cannula into the stomach. Grasp the looped placement wire with a retrieval snare. Withdraw the retrieval snare into the endoscope channel. Fig. 2
12. Remove the endoscope and the looped placement wire through the oropharynx. Pull approximately 5 inches (13 cm) of the looped placement wire from the mouth.

Fig. 2
13. Slowly and smoothly feed the looped placement wire into the introducer cannula as the endoscope is retracted. Keep the introducer cannula in place in the stomach with the distal end of the placement loop outside the abdomen. Fig. 3
14. Connect the looped placement wire with the tube loop. Fig. 4
15. Lubricate the MIC® PEG Tube with a water-soluble lubricant. Apply traction to pull the placement loop and the tube back through the oropharynx, esophagus, and into the stomach. Fig. 5
16. Re-enter the esophagus with the endoscope and visually follow the gastrostomy tube as it enters the stomach. Slide the introducer cannula out of the incision site and gently pull the PEG distal tip through the abdominal wall.
17. Use a rotating motion to slowly work the tube up and out until the internal bumper is fully seated against the gastric mucosa.

Note: Gastrostomies mark on the body of the tube will assist in determining the progress of the tube as it exits the abdomen.

Caution: Do not use excessive force to pull the tube into place. This could harm the patient and damage the tube.
18. Clean the tube and stoma site and apply a sterile gauze dressing. Cut the tube loop wire with scissors and discard the tube loop and placement wire.

19. Slide the external bolster over the proximal end of the MIC® PEG Tube and push the external bolster into place next to the sterile gauze dressing. Visually verify that the internal bumper is properly placed. Remove the endoscope. The external bolster should be positioned approximately 2 mm above the skin.

Caution: Do not apply excessive tension. There should be no compression of the gastric mucosa or the skin. Optionally, a suture loop (not supplied) may be tied around the external bolster to maximize movement of the MIC® PEG Tube while the stoma is healing.
20. Cut the MIC® PEG Tube straight across, leaving an appropriate length to place the external bolster. Fig. 6 Discard the removed portion of the tubing.
21. Slide the clamp on the MIC® PEG Tube.
22. Insert the barb connector of the MIC® Feedthrough Adapter completely into the proximal end of the MIC® PEG Tube.

Skin and Stoma Care
1. Keep the skin around the MIC® PEG Tube stoma site clean, dry, and free of drainage.
2. After the stoma is healed, a dressing is not necessary with the MIC® PEG Tube and may even cause moisture retention in skin irritation.

Removal of the MIC® PEG Tube
The MIC® PEG Tube should be removed by either traction removal through the stoma or through endoscopic retrieval.

Caution: It is not recommended that a portion of the tube be cut to allow the internal bumper to pass.

Caution: When the 14 Fr PEG is used, endoscopic removal method only.

Warning: Never attempt to change the tube unless trained by the physician or other health care provider.

Traction Removal of the MIC® PEG Tube
1. When the physician determines that the tract is formed (usually within 4-6 weeks after placement of PEG), the MIC® PEG Tube may be replaced with an alternative feeding device. We recommend using one of the following:
- MIC® Key™ Low-Profile Gastrostomy Tube
- MIC® Gastrostomy Tube

2. To remove the tube, prop the patient for MIC® PEG Tube endoscopic removal using standard procedure.
3. Cut the MIC® PEG Tube at skin level.
4. Retrieve the MIC® PEG Tube using endoscopic tools according to facility protocol.
5. Replace the MIC® PEG Tube with the appropriately sized gastrostomy tube.

Feedthrough Adapter with ENFit™ Connectors Replacement Procedure
1. Cleanse the skin around the stoma site and allow the area to air dry.
2. Clamp the tube and trim the MIC® PEG Tube as necessary using scissors. Cut the tube straight across.
3. Push the Replacement Feedthrough Adapter with ENFit™ Connectors completely into the MIC® PEG Tube.
4. Unclamp the tube to remove use.

Tube Patency Guidelines
Proper tube flushing is the best way to avoid clogging and maintain tube patency. The following are guidelines to avoid clogging and maintain tube patency:
- Flush the feeding tube with water every 4–6 hours during continuous feeding, anytime the feeding is interrupted, or before and after every intermittent feeding, or at least every 8 hours if the tube is not being used.
- Flush the tube before after checking gastric residuals. Flush the tube every 1–2 hours in adults, 3 to 4 hours in children. Do not flush the tube more than every 4 hours if the tube is not being used.
- Flush the feeding tube before and after medication administration and between medications. This will prevent the medication from interacting with formula and potentially causing the tube to clog. Do not use liquid medication when possible and consult the pharmacist to determine if it is safe to use with gastrostomy feeding tube. Never crush enteric-coated medication or mix medication with formula. Avoid using acidic flushes such as cranberry juice and cola beverages to flush feeding tubes at the acidic quality when combined with formula proteins may actually contribute to tube clogging.

General Flushing Guidelines
Flush the feeding tube with water using an ENFit™ syringe every 4–6 hours during continuous feeding, anytime the feeding is interrupted, or at least every 8 hours if the tube is not being used. Flush the feeding tube after checking gastric residuals. Flush the feeding tube before and after medication administration. Avoid using acidic irrigants such as cranberry juice and cola beverages to flush feeding tubes.

Unclamp the MIC® PEG Tube before flushing.
- Use a 30 to 60 ml ENFit™ syringe. Do not use smaller size syringes as this can increase pressure on the tube and potentially rupture smaller tubes.
- Ensure the second access port (if applicable) is closed with the tethered cap prior to flushing.
- Use room temperature water for tube flushing. Sterile water may be appropriate where the quality of municipal water supplies is of concern. The amount of water will depend on the patient’s needs, clinical condition, and type of tube, but the average volume ranges from 10 to 50 ml for adults, and 3 to 10 ml for infants. Hydration status also influences the volume used for flushing feeding tubes. In many cases, increasing the flushing volume can avoid the need for supplemental intravenous fluid. However, individuals with renal failure and other fluid restrictions should receive the minimum flushing volume necessary to maintain tube patency.
- Do not use excessive force to flush the tube. Excessive force can penetrate the tube and can cause injury to the gastrointestinal tract.
- Document the time and amount of water used in the patient’s record. This will enable all caregivers to monitor the patient’s needs more accurately.

Caution:
- Do not use excessive force to flush the tube. Excessive force can penetrate the tube.
- Do not use excessive force to pull the tube into place. This could harm the patient and damage the tube.

Note:
- Pressure Necrosis
- Intraperitoneal Leakage
- Stomach Ulcers
- Infection

The following complications may be associated with any gastrostomy feeding tube:

Removal of the MIC® PEG Tube
1. When the physician determines that the tract is formed (usually within 4-6 weeks after placement of PEG), the MIC® PEG Tube may be replaced with an alternative feeding device. We recommend using one of the following:
- MIC® Key™ Low-Profile Gastrostomy Tube
- MIC® Gastrostomy Tube

2. To remove the tube, prop the patient for MIC® PEG Tube endoscopic removal using standard procedure.
3. Cut the MIC® PEG Tube at skin level.
4. Retrieve the MIC® PEG Tube using endoscopic tools according to facility protocol.
5. Replace the MIC® PEG Tube with the appropriately sized gastrostomy tube.
Daily Care & Maintenance Check List

<table>
<thead>
<tr>
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<td>Clean the feeding tube</td>
<td>Use warm water and mild soap being careful not to pull or manipulate the tube excessively. Rinse thoroughly and dry well.</td>
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<tr>
<td>Clean the gastric ports</td>
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</tr>
<tr>
<td>Rotate the tube</td>
<td>Rotate the tube 360 degrees plus a quarter turn daily.</td>
</tr>
<tr>
<td>Verify placement of the external bolster</td>
<td>Verify that the external bolster rests 1–2 mm above the skin.</td>
</tr>
<tr>
<td>Flush the feeding tube</td>
<td>Flush the feeding tube as described in the General Flushing Guidelines section above.</td>
</tr>
</tbody>
</table>

Tube Occlusion

- Tube occlusion is generally caused by:
  - Poor flushing techniques
  - Failure to flush after measurement of gastric residuals
  - Inappropriate administration of medication
  - Pill fragments
  - Thick formulas, such as concentrated, blenderized, or enriched formulas that are generally thicker and may contain particulates
  - Formula contamination that leads to coagulation
  - Reflux of gastric or intestinal contents up the tube

To Unclog a Tube

1. Make sure that the feeding tube is not kinked or clamped off.
2. If the clog is visible above the skin surface, gently massage or milk the tube between fingers to break up the clog.
3. Connect an ENFit™ syringe filled with warm water into the appropriate access port of the tube and gently pull back on then depress the plunger to dislodge the clog.
4. If the clog remains, repeat step #3. Gentle suction alternating with syringe pressure will relieve most obstructions.
5. If this fails, consult with the physician. Do not use cranberry juice, cola drinks, meat tenderizer or chymotrypsin, as they can actually cause clogs or create adverse reactions in some patients. If the clog is stubborn and cannot be removed, the tube will have to be replaced.

Caution: For enteral nutrition and/or medication only.

For more information, please call 1-844-425-9273 in the United States, or visit our website at halyardhealth.com.

Educational Booklets: “A Guide to Proper Care” and “A Stoma Site and Enteral Feeding Tube Troubleshooting Guide” is available upon request. Please contact your local representative or contact Customer Care.