



Why some caregivers fear their uncommunicative patients may miss their tube feeds

BACKGROUND

There I was, having an interesting conversation in my capacity as a senior nursing officer with a regular caregiver about her mother who is a chronic sick patient in this hospital, when she surprised me with this unprompted declaration: “I worry that my mum may miss a tube feed especially during the night and gone hungry without anyone realizing.” Her mother has a tracheotomy and is uncommunicative. The normally calm daughter-caregiver didn’t start raising her voice, but she was not far off. She formed her grim conjecture after checking inside her mum’s milk-powder tin and showing to me the level of powder in it against where she thought it ought to be. Talking to the other caregivers in the ward, I found more than a few having similar concerns.

Superficially, this sounds strange as nurses constantly communicate with one another when handing over their patients, but admittedly, the potential for a bad patient outcome, not least a nasty service furor, due to miscommunication over tube feeds in the case of uncommunicative patients is so much higher.

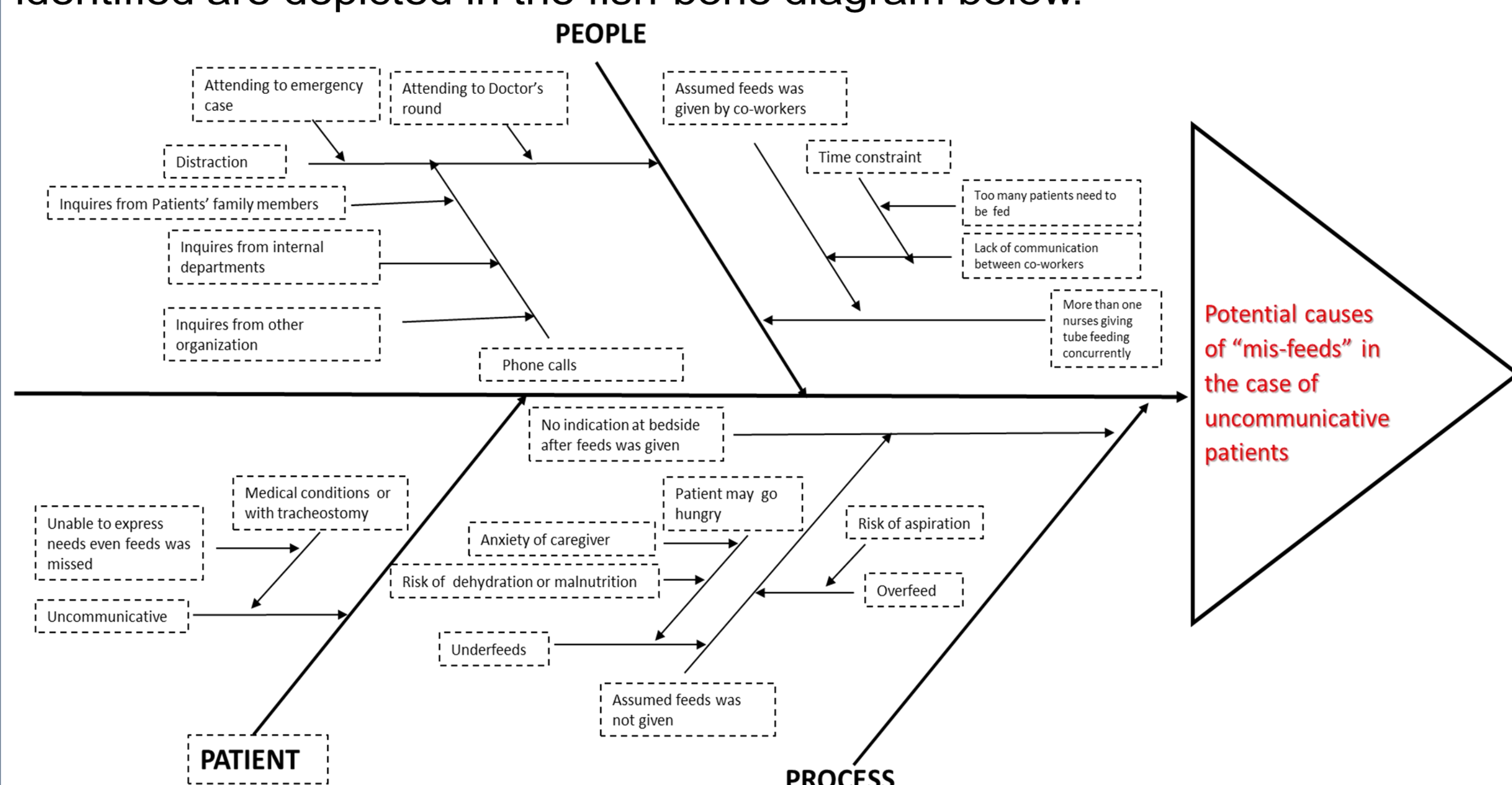
PROJECT AIMS

1. To allay caregiver anxiety about the administration of tube feeding regime for uncommunicative patients.
2. To improve inter-staff communication and reduce the potential for feeding errors or “mis-feeds”.

ANALYSIS

It is hard to dispute in spite the lack of documented evidence that the possibility for staff to miss a feed or overdosing one is exceptionally real in the case of patients who have been uncommunicative due to medical conditions, such as a tracheostomy. Currently, nurses rely on oral updates from each other when handing over the status of their patients’ scheduled tube feeds, but when there is a breakdown in that communication channel, feeding missteps occur.

Another potential source of feeding errors, and this might surprise you, comes from patients’ caregivers who agitate that staff feed their patient now in spite of repeated explanations and assurances the scheduled feed has been given. It is also a worrying signal of mistrust and a big hygiene issue when some caregivers are opening up milk-powder cans to daily scan the levels inside for clues. Further causes of feeding errors that have been identified are depicted in the fish-bone diagram below.



An analysis of the causes revealed one major fault-line: nurses have been relying entirely on oral handovers regarding tube feeds, and without any communication back-up, bad outcomes ensued when going-off-duty staff failed to pass their feeding updates to their incoming colleagues.

SOLUTIONS

Even though mis-feeds are most likely to be very rare, it takes only one evidenced case to ruin trust in our staff. We need to find a solution and one that also reduces caregiver anxiety. We decided to explore the toolkit of visual communication.

One of the benefits of visual cue is that they offer the concerned observer the empowerment that the information and assurance they seek can be answered immediately, which provides hope to those who might otherwise succumb to unnecessary angst by turning to wild conjectures.

SOLUTIONS

Current Practice

A typical patient feeding schedule (see Fig 1 below) which staff routinely refer to.

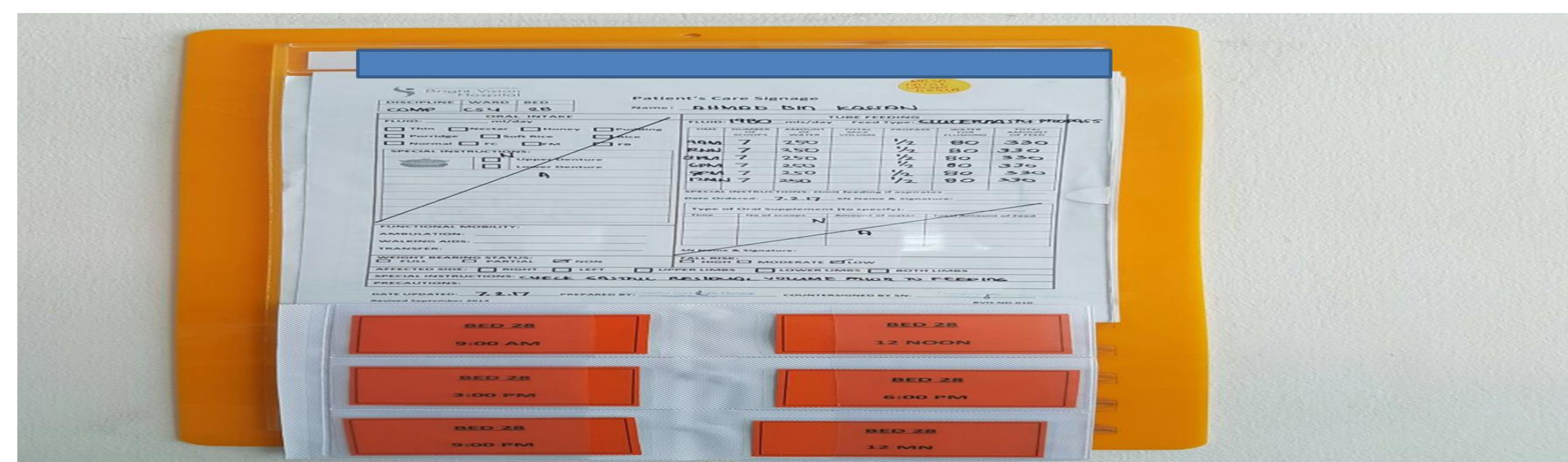
Fig 1:



New Practice

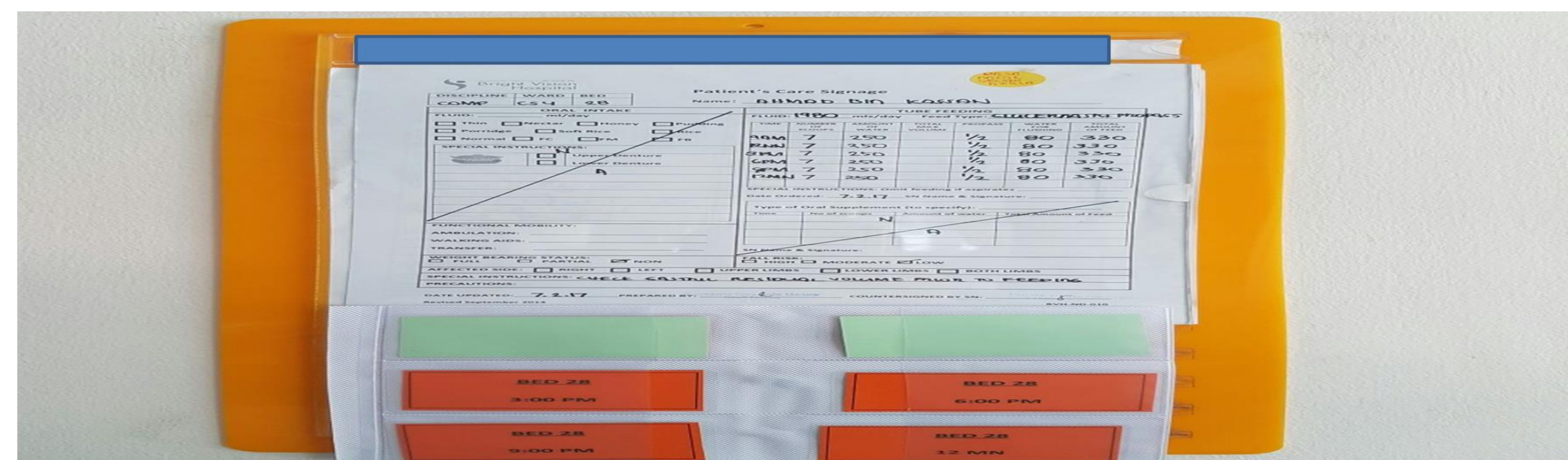
Cards (inscribed with bed no and feeding time) with one side green and the other side amber are deployed as visual cues on patient feeding schedules. Before the first feed in the morning, all the cards on the schedule will show an amber-coloured side (see Fig 2 below).

Fig 2:



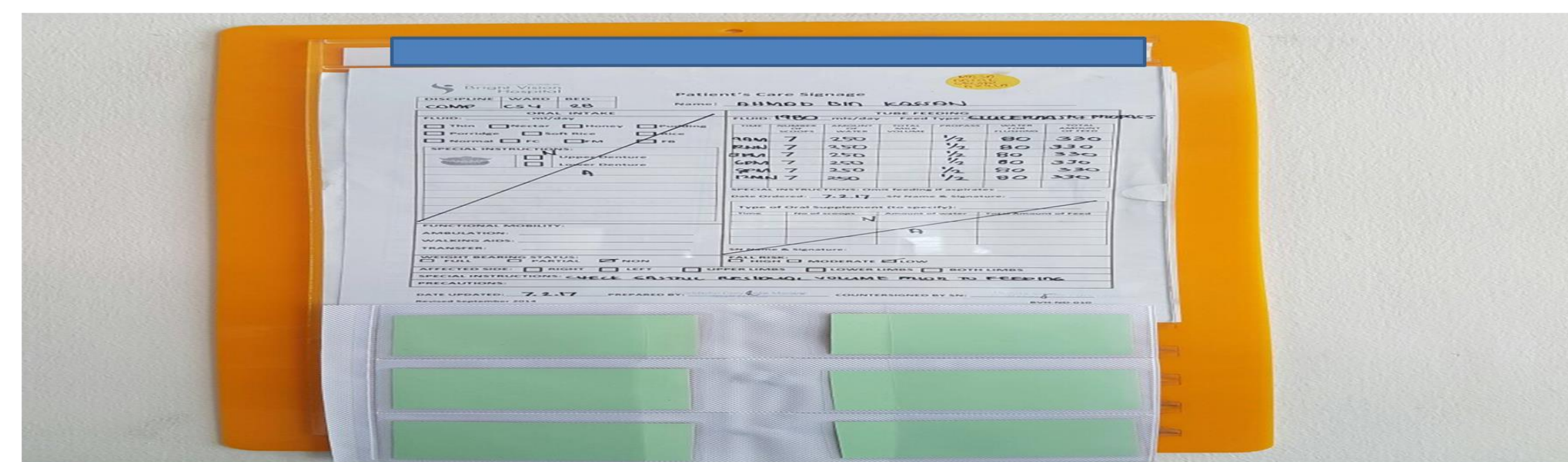
After a feed is given, one card will be turned over to display a green-coloured sided (see Fig 3 below).

Fig 3:



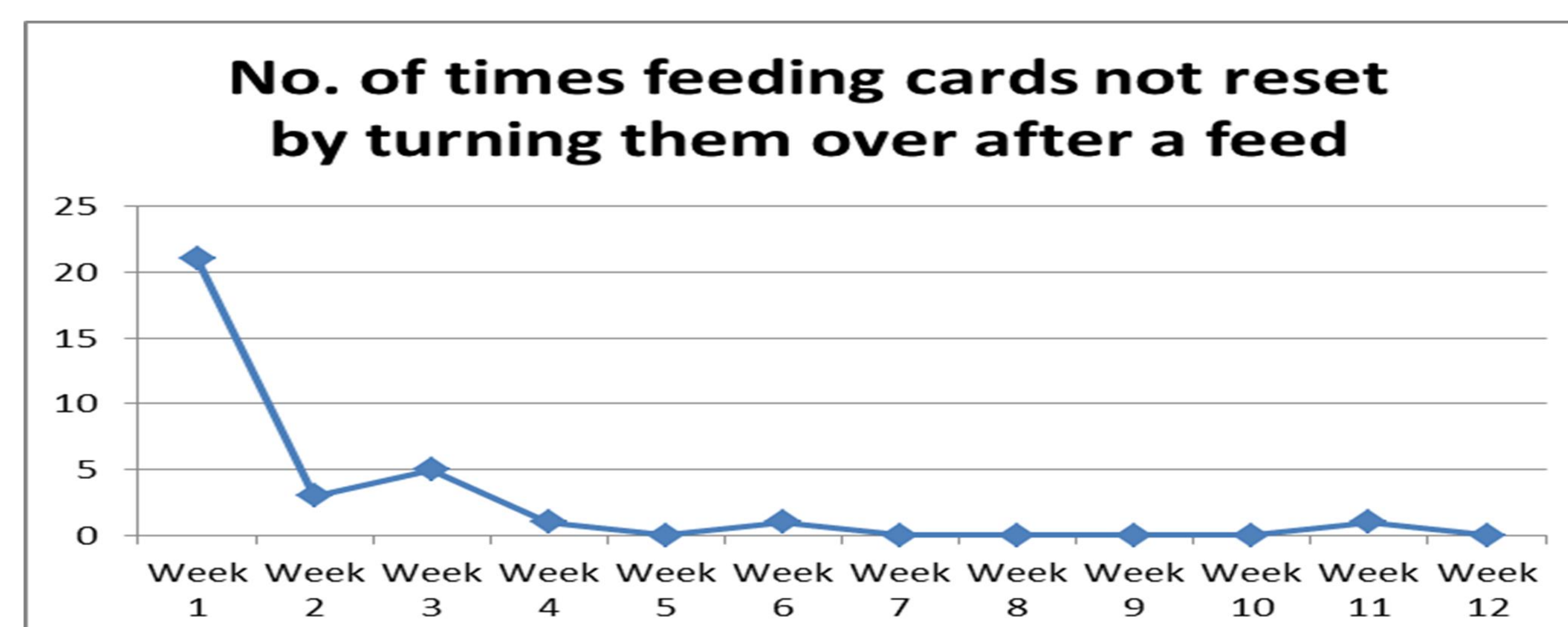
You would have guessed right that, by the end of the day’s feeds, all the cards on the feeding schedule will show their green sides (see Fig 4 below).

Fig 4:



PROJECT’S IMPACT

We collected data over 12 weeks on the number of times the feeding cards were not reset after a feed. It is evident from the chart below that one week after the cards were introduced in a particular ward, staff have started into the habit of turning over the cards after each feed. From 21 instances of staff not resetting the feedings cards after a feed in Week 1, that number has plummeted to just 11 instances over the next 11 weeks. Not bad at all.



SUSTAINABILITY AND SPREAD

The project team know that for this intervention to succeed, it would require regular education, audit and reinforcement. The visual cues have also served another immediate purpose – reassuring anxious relatives whether their loved ones have been fed or not.