

Burn Nurse Insertion of Post Pyloric Dobhoff via Cortrak

Cheri Filewood RN, Lloyd Gambora RN, Sally Sotolo BSN RN, Kara Clayton RD, Emily Lashway-Fitzgerald BSN RN, Sheila Canglet-Tapion BSN RN



BACKGROUND

Burn patients with >20% total burn surface area (TBSA) create a challenge to **maintain adequate nutrition requirements for burn healing**.

The Burn patient's metabolism rate is elevated proportionately to the burn size following fluid resuscitation¹, increasing the caloric requirements for burn healing. Adequate nutrition is essential for the burns to heal.

Burn patients commonly have **frequent surgeries and conscious sedation dressing changes** every few days that require them to be NPO (nothing by mouth).

It is imperative to have minimal interruptions in tube feeds to meet the patient's caloric needs to heal the burn.

PURPOSE

The aim of this performance improvement (PI) project is to

- ❖ Identify patients requiring tube feeds to meet their caloric needs due to not meeting caloric needs with a regular meal tray
- ❖ To minimize the time the patient needs to be NPO for surgery and conscious sedation dressing changes
- ❖ To minimize stopping the tube feeds during routine dressing changes

METHODS

Burn Nurse Superusers have been specifically trained to insert post-pyloric feeding tubes at the bedside using Cortrak, an enteral access system.

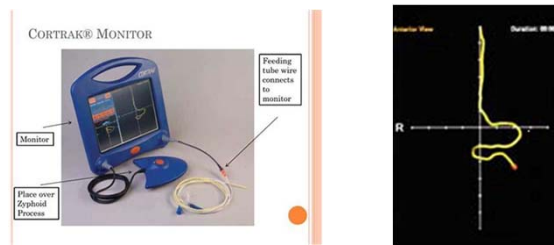
Once the **Cortrak postpyloric feeding tube** is placed, an abdominal radiograph (KUB view) is ordered and placement verified by the radiologist/physician, enteral feedings can then be initiated. The **Burn Registered Dietician (RD)** assesses and follows all burn patients, monitors the nutritional requirements, and assists in identifying patients in need of post-pyloric feeding tube placement.

RESULTS

Burn Nurses placing post-pyloric feeding tubes at the bedside have resulted in **more timely insertions**.

Post-pyloric tube placement **allows feedings to continue** up to the time patients go to Surgery, and the start of conscious sedation dressing changes.

Tube feedings can be continued throughout the dressing changes. This **decreases the time the patients are required to be NPO**.



CONCLUSIONS

This performance improvement team looks to continue to increase the number of Burn Nurse Superusers to place a post-pyloric feeding tube at the bedside.

The Burn team with the Burn RD has would like to propose inserting post-pyloric feeding tubes at the bedside via Cortrak in all patients with a burn greater than 20% TBSA. Post pyloric feeding tubes would be placed within 2 hours of arrival to UMC Lions Burn Center and dietary labs would be drawn twice a week.

Once tolerating tube feeds for 24 hours, ventilated patients receive a weekly metabolic cart to monitor the patient's caloric and protein needs for healing and decrease bacterial translocation.

The burn team, with the Burn RD would monitor admit and daily weights to assess the tolerance of the enteral feeds.

The proposed research study would look to initiate tube feeds early, to improve caloric and protein intake, decrease inflammatory mediators.

REFERENCES

References available upon request

