



Positioning and Tube Feeding

Guidelines
And Considerations

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Reflux with Tube Feeding



- Combination of gravitational back flow and impaired gastro-esophageal sphincter function
- Greatest with NG tube
- 30% of tracheostomies
- 12.5% of neurological patients

Aspiration

A decorative graphic at the top of the slide consists of two groups of three circles. The first group on the left has a solid light purple circle on the left, a white circle with a light purple outline in the middle, and a white circle with a light purple outline on the right. The second group on the right has a solid light purple circle on the left, a white circle with a light purple outline in the middle, and a solid light purple circle on the right.

- Aspiration of secretions
- Secretions colonized with bacteria

Studies form ICU



- Patient vent dependent and fed via tube
- Decreased risk of aspiration when head of the bed was elevated at least 30°

- Bowman et al. (2005)



Nursing Research (Jan/Feb 2010)

- Recommendation for Practice
 - Head of bed elevated 30° to 45°
 - During and for 30 to 60 minutes after feeding

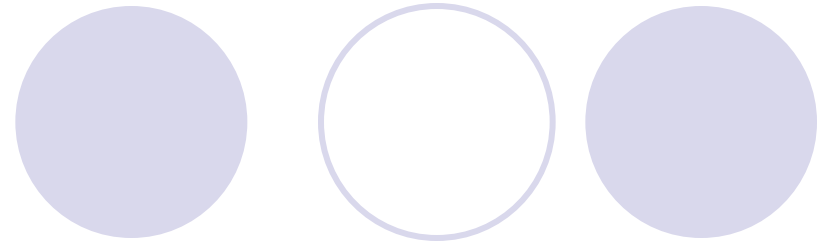
- Kenny and Goodman Care of the Patient with Enteral Tube Feeding: An Evidence-Based Practice Protocol

Physical Therapy



- Research regarding positioning
- But not related to enteral feeding

Positioning



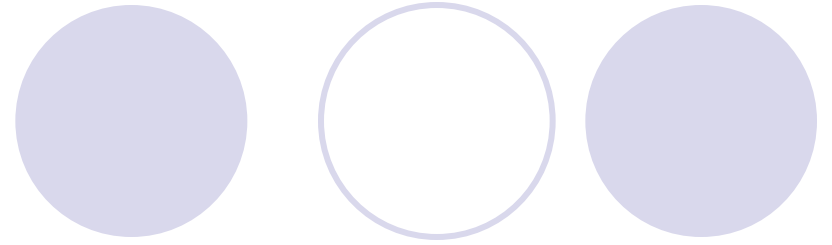
- Shared domain
- PT can learn from nurses
- Nurses can learn from PT



Other Considerations

- Fixed deformities
- Skin problems
- Abnormal muscle tone/control
- Oxygen transport issues

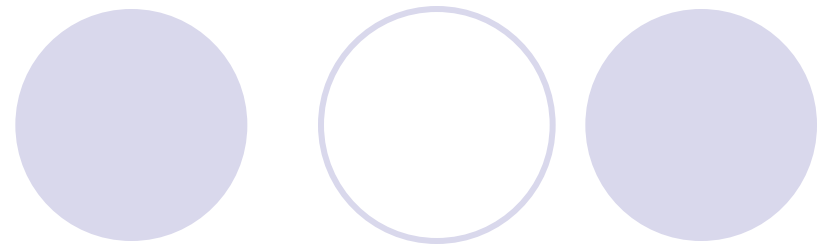
Fixed Deformities



- Scoliosis
- Kyphosis
- Hip deformities
- Combination of all of the above

Scoliosis

- Different curves
 - S
 - C
- Rotational component
- Positioning issues
 - Collapsed side
 - Oblique pelvis
remember the hips



Kyphosis

- Head placement and managing oral secretions
- 30° of elevation and rib cage



Hip Deformities and Positioning

- Fixed adduction
- Fixed abduction
- Lack of hip flexion
- Fixed hip flexion



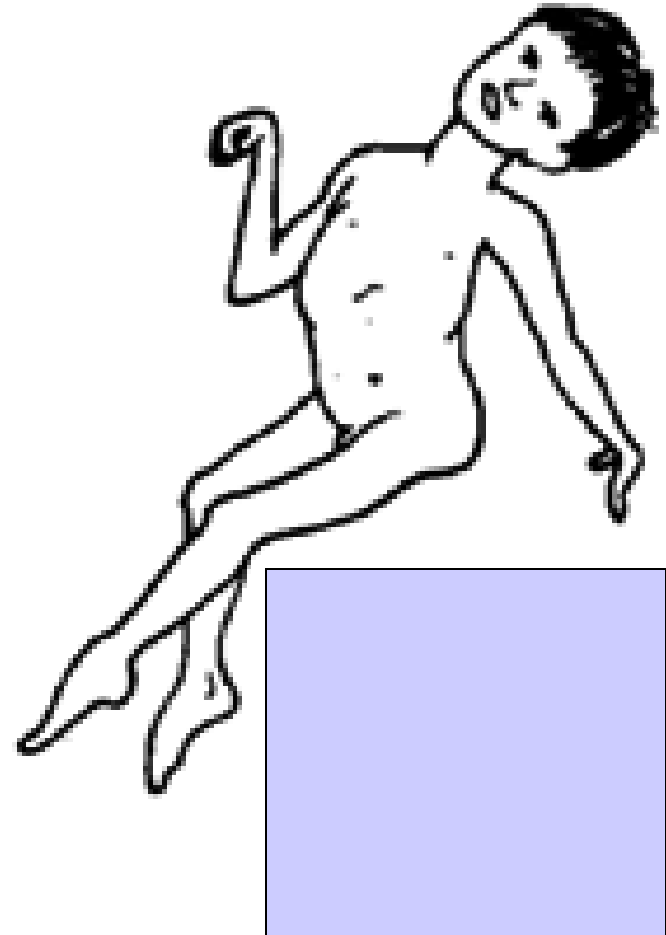
Combination

- Often deformities are combined



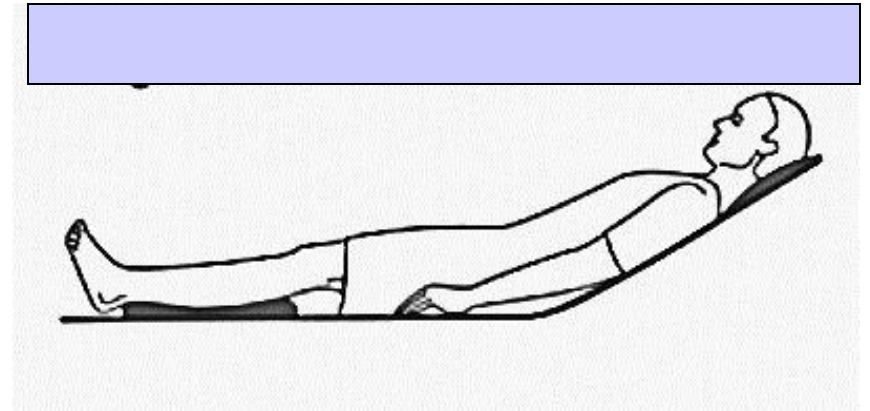
Abnormal Muscle Tone

- Extensor tone
- Flexor tone



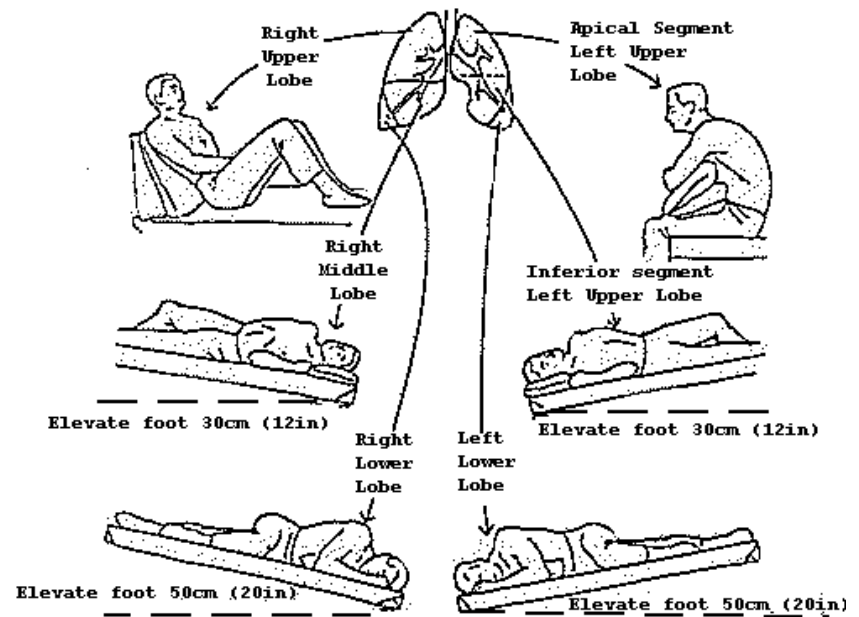
Skin Integrity

- Shear and skin breakdown



Oxygen Transport

- Best O² transport
- Value in change

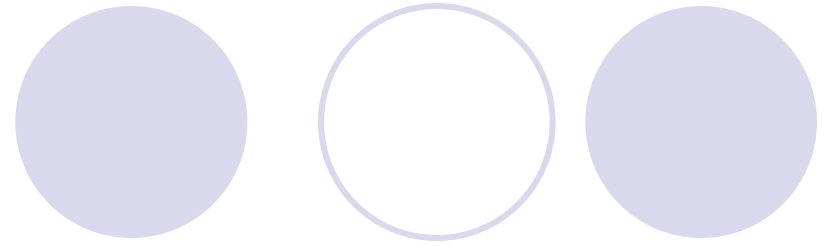


Behavioral Considerations

- Ability to move out of prescribed position
- Habitual poor posture



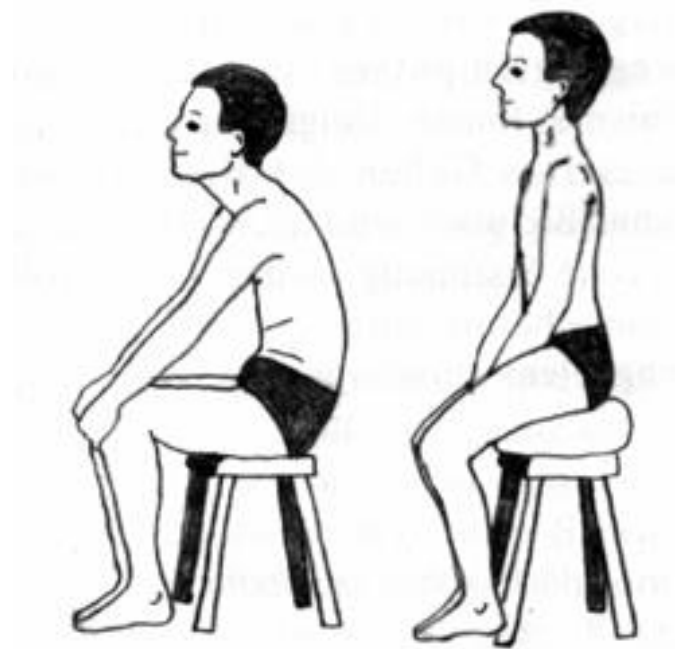
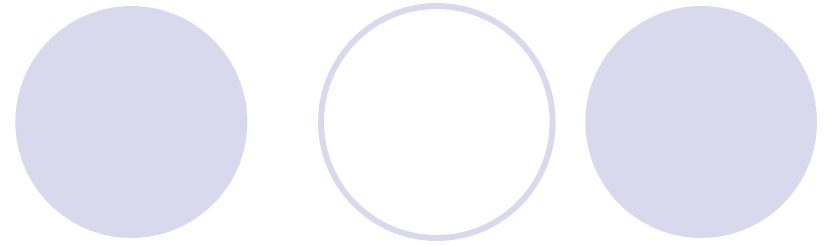
Some Oral Intake



- Impact of pelvis on head
- How do we look at head position
- 90-90-90
- Equipment

Where to Begin?

- The pelvis

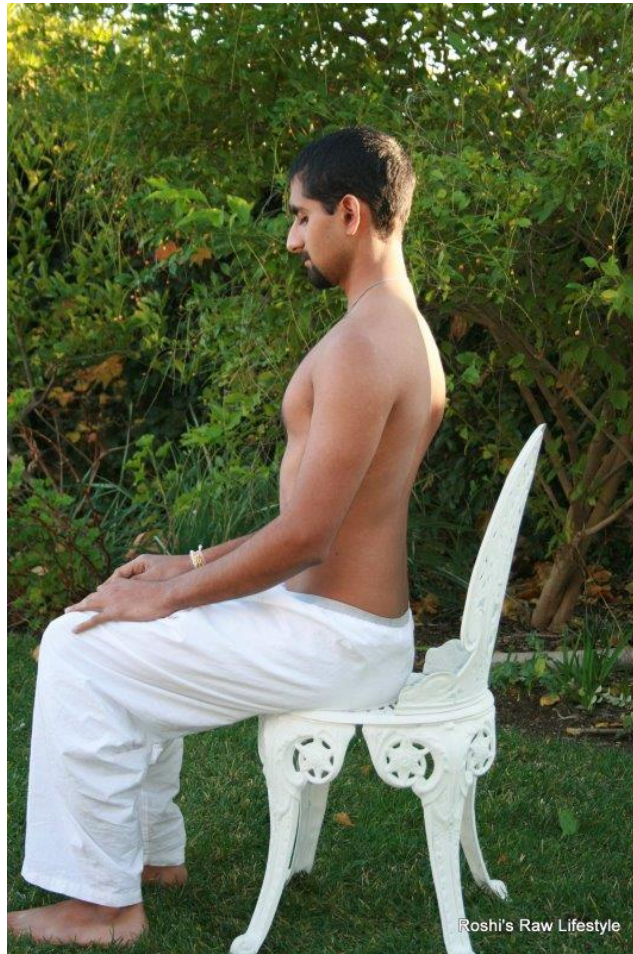


Most Common Problem

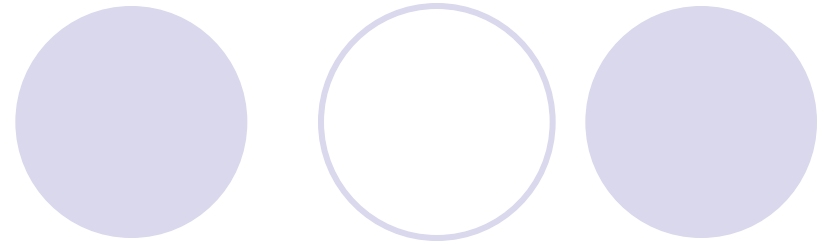
- Posterior pelvic tilt
- Causes
 - Lack of hip flexion
 - Tight hamstring
 - Chair or wheelchair seat depth



Normal Spinal Curves



Head Position



- Recommendation from SLP literature
 - Sit upright
 - Tuck chin
 - Avoid chin elevation

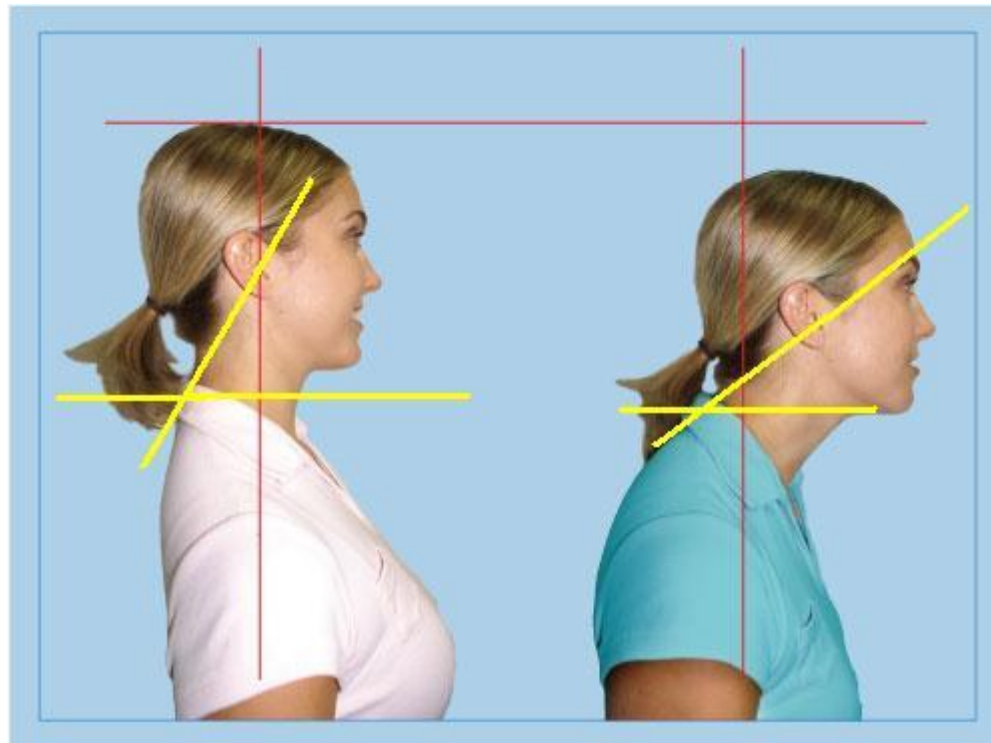
What we mean

- In study 3 of 5 different positions were identified as chin tuck posture



Okada 2007

Looking at Head Posture



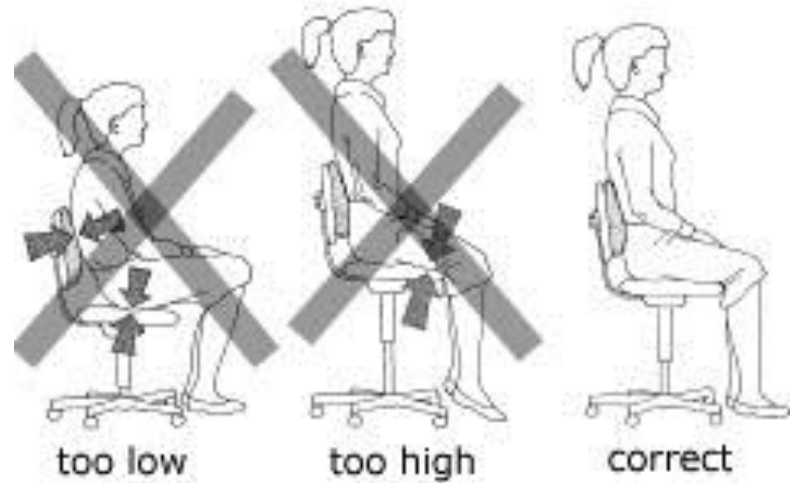
When Sitting Upright May Not Be Best

- Fixed kyphosis
- Tilt-in-space



Check the Chair/Wheelchair

- Seat to floor



Seat Depth

Seat too long



Hangers on Wheelchairs

- Tight hamstrings and 70° hangers



Trunk Rotation

- Back to seat angle
- Midline positioning and fixed hip abduction or adduction

